

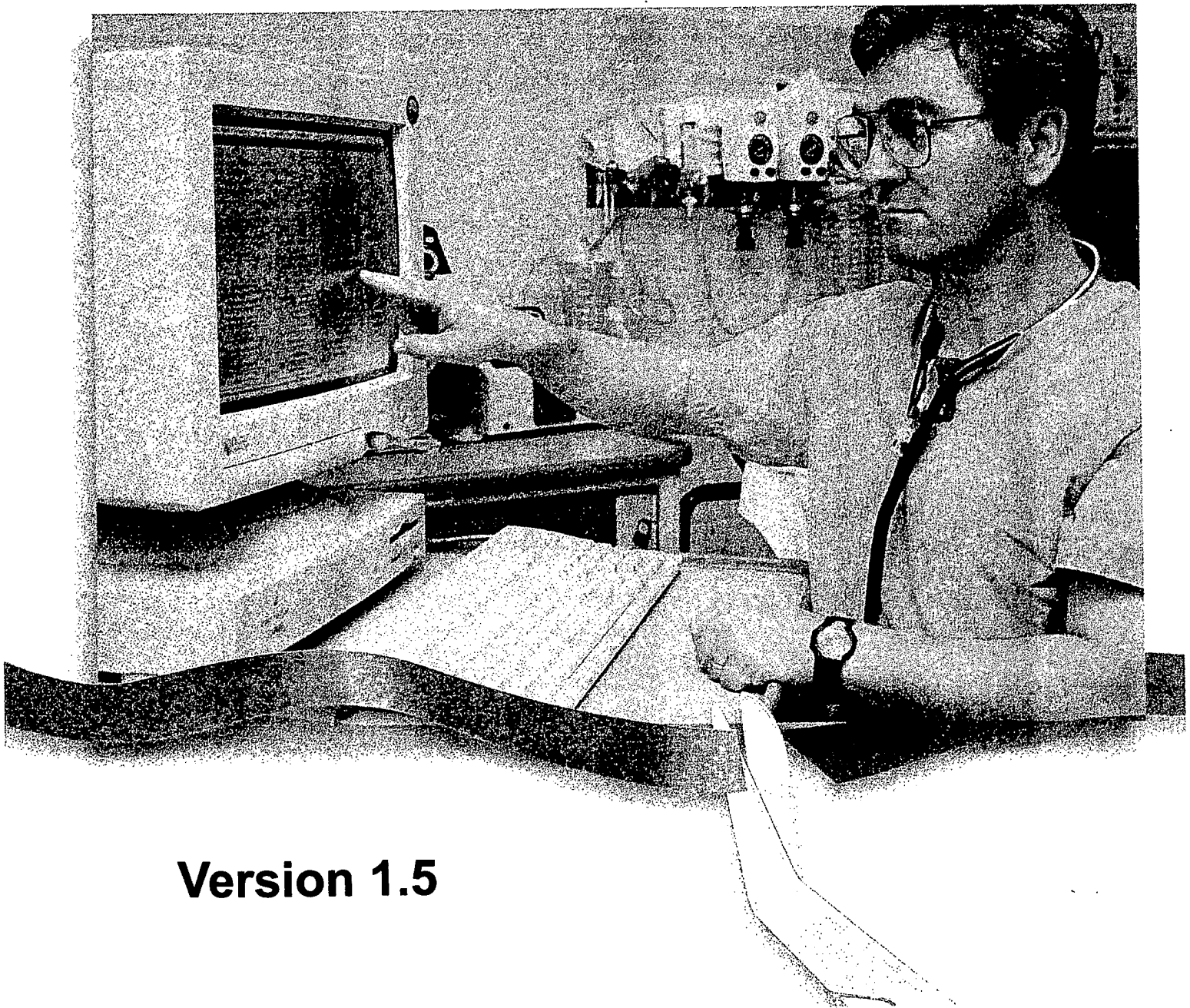
EXHIBIT A

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TeleMed

User's Guide



Version 1.5

BEST AVAILABLE (USPTO)

User's Guide

TeleMedTM

Version 1.5

RLIS, Incorporated

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Chapter 1: Introducing TeleMed

TeleMed is designed to complete repetitive, time-consuming documentation tasks in a fraction of the time it usually takes, so you can concentrate on using your medical knowledge to deliver quality patient care. TeleMed captures the patient data once, then lets you build on the patient's record as new information becomes available thereby allowing Emergency Department staff to concentrate on the patient rather than the patient record. With its speed and ease of use, TeleMed demonstrates it is truly a system that understands the urgency of emergency department operations.

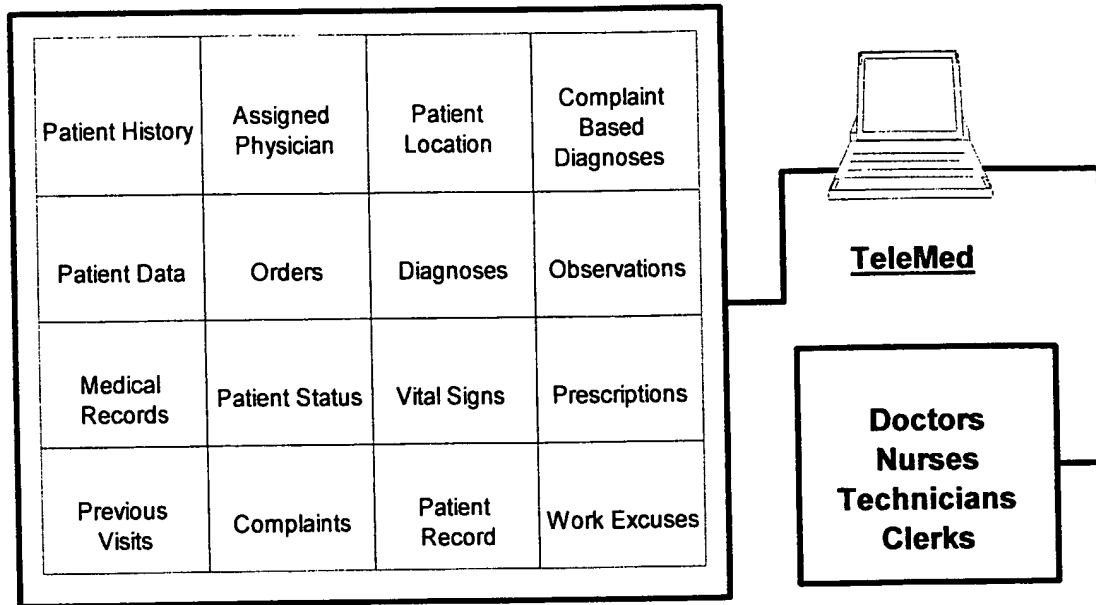


Figure Chapter 1: -1: Type of Information Managed by TeleMed

(Image:tm-3.af3)

From any station, members of your emergency department staff can review up-to-the-minute status of patients or update their medical records.

TeleMed's technology helps your medical staff document their observations and diagnoses as quickly as they make them. It displays comprehensive lists of potential diagnoses based on the complaints they select and takes them logically through the steps when a new patient appears at the door. From complaint to consultation, from diagnosis to referral, your emergency department physicians will be spoiled by the immediacy of response and the ease of moving between screens to capture information on each patient.

With a terminal at every bedside, nurses' station, and doctors' workroom, TeleMed allows everyone in your emergency department operation access to the vital information they need to do their jobs. It centralizes the patient medical record, retrieves data and allows you to review a patient's previous visits. It can identify patient location and status at a glance, so you can tell which patients have not been assigned a physician and where your empty beds are.

With TeleMed, you can dramatically reduce your dictation and transcription costs. Most of the medical record is documented directly by TeleMed without dictation. The system takes entries and translates them into a plain English sentence format that is comfortably familiar. When the physician is working on a patient, that information is entered directly into the medical record. The physician then focuses attention on the patient's condition, potential diagnoses, tests required, and medications to be given. This not only speeds the documentation process but avoids clerical errors associated with dictation. Transcription errors are easily corrected at any terminal.

Documentation has always been a burden but with TeleMed, we make it a pleasure. Each staff member will have a sense of relief at the reduction in paperwork which will in turn boost morale and reduce turnover. The computer software takes care of most of the redundant, administrative headaches and allows your medical staff to focus on patient care and treatment.

Documentation has become a necessary evil for most medical facilities. With TeleMed, every case is thoroughly documented. Physicians and nurses contribute to the overall picture of each patient, and discrepancies can be resolved immediately rather than after the fact. Calls to primary or consulting physicians are logged so you track when events occurred. Requests to various departments for tests are logged and printed. When those results are received, the status changes on the screen so physicians know when new information is available.

With over 200 screens to assist you and easy, logical paths between them, TeleMed provides powerful support to all your medical staff. By tailoring our system to emergency department operations, the administrative functions of creating medical records and managing patients becomes enjoyable.

With TeleMed, your emergency department can be more profitable, more productive, and more professional. Designed by an emergency department physician, the TeleMed system helps your emergency department physicians practice medicine, rather than focusing 40% of their time and energy on documentation.

With the TeleMed system in place, you can work more effectively and quickly to handle patients in the emergency department. That translates into higher volume for your hospital, improved patient care and ultimately greater efficiency for your physicians. When patients arrive and are faced with significant delays, they will seek care elsewhere. TeleMed helps eliminate those delays. Patients are evaluated, treated, and discharged from the emergency department in a quick, thorough and consistently reliable manner.

TeleMed Tasks And The Typical Roles That Perform Them

The following chart lists some of the typical roles and associated tasks they can perform with TeleMed.

	Doctor	Nurse	Tech	Clerk	Comment:
Enter New Patient	•	•			
View Clinical Summaries	•	•			
Edit Doctor Drug Preferences	•				
Create Prescriptions	•				
Order Medications	•	•			
Order Therapeutics	•	•			
Generate Reports	•	•		•	
Quit Program	*				Optional
Edit Users	*				Optional
System Manager	*	*			Optional
Delete Insurance Plans	*				Optional
Edit Prephrased Text	*				Optional
Sign Physician Med. Record	*				Optional
Sign Nurse Medical Record		*			Optional

Table Chapter 1: -1: Typical TeleMed Tasks & Roles Chart

NOTE: The tasks that an individual is authorized to perform in TeleMed are driven by your medical operation's policies and procedures. This chart is intended to familiarize those new to TeleMed and is not intending to influence your medical operation's policies or procedures.

Chapter 2: Getting Acquainted with TeleMed

Active Patient List (Main Tracking Screen)

Active Patient List										Active User: James Ross, Jr., MD	
Location	Name	Physician	Seen By	Order	X-ray	Lab	Test	Dictate	Vital	Pri	Elim
03	Alvarez, Byrd	Guerrero	P	N					V	4	
G5a	Garbo, Greta	J.E.Ross, MD	P	N	x	L			V	2	
R3b	Byrd, Biddie T		P	N					V	4	
R3c	Redford, Robert X	D.Foley, MD	P	N				d	V	1	
Unknown	Byrd, Fickle	J.F.Bragan, MD	P	P		I		d	V	4	
Unknown	Byrd, Newby	J.E.Ross, MD	P	N					V	4	

Medical Information
Outstanding Orders
Latest Vitals
Phone Directory
ED Layout
Waiting Patients
Patient Complaints
NonDictated
New Visit
Change
Patient History
Utilities
Clear User

Figure Chapter 2: -1: Active Patient List (main tracking screen)

(Image: tm-2.bmp)

When you “log in” to TeleMed (via your “smart card”), you will open the “Active Patient List” window. Treat this as your Emergency Department’s “main tracking screen”.

Medical Information (Main Patient Information Screen)

Active User James Ross, Jr., MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 07A

Medical Information		Priority 2	Location 07A	Print Medical Record	Seen By Nurse
INPUT		HISTORICAL			Seen By Doctor
Triage	Vital Signs	Summary			Record Dr. Interval
Complaint	Progress Notes	Vital Signs			Phone Directory
Differential Diagnosis	Lab Requests	Prog. Notes Summary			Department Clerk
Diagnosis	Radiology Requests	Lab Results			Patient Instructions
	Test Requests	EKG Results			Work Excuse
Prephrased Text	Diagnostic Procedures	Transcript Editor			School Excuse
Review of Systems	Therapeutics	Therapeutics Summary			Patient Questionnaire
Allergies	Medications in ER	Prescribed Meds			Physician
Past Medical History	Prescriptions	Consultation Log			Employer/Contact
Family History	Consultations	Referral Log			Admission
Social History	Referrals	Dr. Interval			Discharge
					Clear User
					Exit

Figure Chapter 2: -2: Medical Information (main patient information screen)

(Image: medical-info.bmp)

With a single touch of the screen, you can move painlessly through other screens to capture history, enter vital signs or give orders to others. Treat this as your "main patient information screen".

Complaints/Diagnoses

Complaint - Non-Pain

Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752

Pat #: 7564552

SS #: 450-81-9873

Bed: 02

Complaint: 1 of 1				Previous	Next	Add	Clear Complaint	Non-Pain
fall								Pain
								Trauma
								Psychiatric
								Rechecks
Abdominal Distention	Edema/Generalized	Lethargy	Sickle Cell Crisis					
Abscess	Edema/Localized	Memory Loss	Skin Infection					
Allergic Reaction	Fever (Adult)	Miscarriage	Stridor					
Altered Mental Status	Fever (Child)	Nasal Cong/Disc	Stroke					
Anxiety	Hematemesis	Nose Bleed	Syncope/Fainting					
Appetite Loss	Hematuria	Oral Lesion(s)	Tachycardia					
Asthma	Hemoptysis	Overdose	Thirst/Polydipsia					
Behavior Change	Hemorrhoids	Palpitations	Tinnitus					
Cardiac Arrest	Hypertension	Paresthesias	Unconsciousness					
CHF	Hypoglycemia	Poisoning	Urinary Retention					Complaint
Congestion/Nasal	Hypotension	Polyuria	Vaginal Bleeding					Diff. Diagnosis
Constipation	Indigestion	Rash	Vaginal Discharge					Final Diagnosis
Cough	Influenza	Rectal Bleeding	Vertigo					
Decubitus Ulcers	Intoxication	Red Eye	Vision Disturbance					
Diarhea	Itching	Respiratory Failure	Vomiting/Nausea					Clear User
Dizzy	Jaundice	Seizure	Weakness					
DKA/Hyperglycemia	Labor	Sexually Trans Disease	Weight Loss					
Dyspnea	Lesion/Growth	Shock	Wheezing					Exit

Figure Chapter 2: -3: Complaint Screen (Non-Pain)

(Image: complaint-non-pain.bmp)

TeleMed displays listings for trauma and non-trauma complaints. You select as many complaints as apply to the patient. For non-trauma complaints, TeleMed creates a complete list of potential diagnoses, as well as a shorter list of more probable causes. The physician may add or subtract from these differential diagnoses to reflect the causes which were considered. In trauma cases, the physician selects a direct diagnosis, such as burn. Once the final diagnosis is selected, the appropriate information is automatically added to the patient's exit instructions.

Diagnosis (Graphical)

Fracture - Foot

Active User J.E. Ross, MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 02

<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Third Toe <input type="checkbox"/> Second Toe <input type="checkbox"/> Fourth Toe <input type="checkbox"/> Fifth Toe <input type="checkbox"/> Fifth Metatarsal <input type="checkbox"/> Fourth Metatarsal <input type="checkbox"/> Third Metatarsal <input type="checkbox"/> Lateral Cuneiform <input type="checkbox"/> Cuboid <input type="checkbox"/> Calcaneus <input type="checkbox"/> Lateral Malleolus <input type="checkbox"/> Pathologic <input type="checkbox"/> Occult <input type="checkbox"/> Tibial Plafond <input type="checkbox"/> Maissonneuve <input type="checkbox"/> Bosworth <input type="checkbox"/> Bimalleolar <input type="checkbox"/> Trimalleolar		<input type="checkbox"/> Great Toe <input type="checkbox"/> Distal Phalanx <input type="checkbox"/> Proximal Phalanx <input type="checkbox"/> Sesamoid Bones <input type="checkbox"/> First Metatarsal <input type="checkbox"/> Second Metatarsal <input type="checkbox"/> Medial Cuneiform <input type="checkbox"/> Intermediate Cuneiform <input type="checkbox"/> Navicular <input type="checkbox"/> Talus <input type="checkbox"/> Tibia <input type="checkbox"/> Fibula <input type="checkbox"/> Medial Malleolus	Direction <input type="checkbox"/> Transverse <input type="checkbox"/> Oblique <input type="checkbox"/> Spiral Location <input type="checkbox"/> Distal <input type="checkbox"/> Midshaft <input type="checkbox"/> Proximal <input type="checkbox"/> Lateral <input type="checkbox"/> Medial	Displacement <input type="checkbox"/> Non-displaced <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Lateral <input type="checkbox"/> Medial <input type="checkbox"/> Ulnar <input type="checkbox"/> Radial <input type="checkbox"/> Depressed <input type="checkbox"/> Rotary Angulation <input type="checkbox"/> Degrees <input type="checkbox"/> Valgus <input type="checkbox"/> Varus Compression <input type="checkbox"/> %
---	---	--	--	---	--

Type <input type="checkbox"/> Simple <input type="checkbox"/> Comminuted <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Impaction <input type="checkbox"/> Stress <input type="checkbox"/> Torus <input type="checkbox"/> Greenstick <input type="checkbox"/> Avulsion	<input type="checkbox"/> w/Articular Surface Involvement <input type="checkbox"/> % <input type="checkbox"/> w/Posterior D/L <input type="checkbox"/> w/Anterior D/L <input type="checkbox"/> w/Medial D/L <input type="checkbox"/> w/Lateral D/L <input type="checkbox"/> w/Subluxation	<input type="checkbox"/> Salter Type I <input type="checkbox"/> Salter Type II <input type="checkbox"/> Salter Type III <input type="checkbox"/> Salter Type IV <input type="checkbox"/> Salter Type V
---	---	--

Figure Chapter 2: -4: Graphical Diagnosis Screen (typical)

(Image: graphics-foot.bmp)

Often, helpful colorful graphics are provided. In the case above, fracture diagnoses with their modifiers can be quickly entered.

Review Of Systems

Review of Systems		Active User J.E. Ross, MD	
Patient Name Garbo, Greta			
Adm # 1895752	Pat # 7564552	SS # 450-81-9873	Bed 02

Initial (Part 1)		Initial 1	Initial 2	<input type="checkbox"/> Non-Contributory
HEAD		LUNGS		Complete System Review <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Constitutional</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Skin</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Lymphatic</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Bones Joints Muscles</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Hematologic</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Endocrine</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Allergic & Immu. Hist.</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Head</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Neck</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Breasts</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Respiratory</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Cardiovascular</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Gastrointestinal</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Genitourinary</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Neuro</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">Psychiatric</div>
Headache <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Cough <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Syncope <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Sputum Production <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Recent Head Trauma <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hemoptysis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Ears	Pleuritic Chest Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Deafness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Tinnitus <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	HEART			
Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Chest Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Eyes	Palpitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Visual Complaint <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Orthopnea <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Photophobia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Dyspnea when Sleeping <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Inflammation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Dyspnea on Exertion <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Discharge <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	MUSCULOSKELETAL			
Nose	Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Rhinitis <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness to Extremities or Joints <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Sinusitis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	SKIN			
Mouth and Throat	Rash <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Sore Throat <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Lumps <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Dysphagia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Easy Bruising <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Bleeding Gums <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Pregnant <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Ulcers <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> UNABLE TO RESPOND			
Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Neck				
Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Stiffness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				

Figure Chapter 2: -5: Review of Systems Screen (Initial - Part 1)

(Image: review of systems.bmp)

TeleMed provides comprehensive groupings of all systems and allows the physician to move freely back and forth without the tedium of exiting through a number of screens. You only enter what is needed without being forced to enter unnecessary information. TeleMed then generates the appropriate level of documentation to maximize billing.

Past Medical History

Past Medical History

Active User J.E.Ross, MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 02

<input checked="" type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input checked="" type="checkbox"/> Back Injury <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blindness <input type="checkbox"/> Cancer <input type="text"/> <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colitis <input type="checkbox"/> Congenital Heart Dis. <input type="checkbox"/> Deafness <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis	<input type="checkbox"/> Ear, Nose, Throat Dis. <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Emphysema <input type="checkbox"/> Eye Disease <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Gallstones <input type="checkbox"/> Gout <input type="checkbox"/> Headaches <input type="checkbox"/> Head Injury <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV+ <input type="checkbox"/> Hives <input type="checkbox"/> Irregular Heart Beat	Past Hospitalizations <input type="checkbox"/> Kidney Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lupus <input type="checkbox"/> Measles, Mumps <input type="checkbox"/> Mental/Emotional Problems <input type="checkbox"/> Mental Illness <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Meningitis <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Panic Attacks/Anxiety <input type="checkbox"/> Physical Disability <input checked="" type="checkbox"/> Pneumonia <input type="checkbox"/> Seizures/Epilepsy	0 Past Hospitalizations Recorded <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="text"/> <input type="checkbox"/> None Other <input type="text"/>
Past Surgical History			
<input type="checkbox"/> Aneurysm <input checked="" type="checkbox"/> Appendectomy <input type="checkbox"/> Back <input type="checkbox"/> Brain <input type="checkbox"/> Breast <input type="checkbox"/> Broken Bones <input type="checkbox"/> Carotid <input type="checkbox"/> Cataracts <input type="checkbox"/> Coronary Bypass	<input type="checkbox"/> Cosmetic <input checked="" type="checkbox"/> C-Section <input type="checkbox"/> Dental <input type="checkbox"/> Exploratory <input type="checkbox"/> Eye <input type="checkbox"/> Gallbladder <input type="checkbox"/> Heart <input type="checkbox"/> Heart Catheter <input type="checkbox"/> Hemorrhoid	<input type="checkbox"/> Hernia Repair <input type="checkbox"/> Hip <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Knee <input type="checkbox"/> Lung <input type="checkbox"/> Ostomy <input type="checkbox"/> Peripheral Vascular <input type="checkbox"/> Retinal Laser <input type="checkbox"/> Sinus <input type="checkbox"/> Spinal	<input type="checkbox"/> Thyroid <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Transplant Corneal <input type="checkbox"/> Transplant Heart <input type="checkbox"/> Transplant Kidney <input type="checkbox"/> Transplant Liver <input type="checkbox"/> Transplant Lung <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> None Other <input type="text"/>
<input type="checkbox"/> Request Past Medical Charts <input type="checkbox"/> Charts Have Been Requested			
<div style="text-align: right;"> <input type="button" value="Exit No-Save"/> <input type="button" value="Clear User"/> <input type="button" value="Exit"/> </div>			

Figure Chapter 2: -6: Past Medical History

(Image: past-med-history.bmp)

You can now look up a patient's past medical history without ever touching a stack of paper. Prior visits can be reviewed easily and quickly by identifying the patient by name, Social Security number, or medical record number.

Allergies

Allergies Active User J.E. Ross, MD
 Patient Name Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Demerol 50mg

ACE Inhibitors	Cephalosporins	Novocain	None
Adhesive Tape	Codene	Penicillin	
Alcohol	Compazine	Phenothiazines	
Antihistamines	Decongestants	Quinolones	
Antiinflammatories	Demerol	Reglan	
Aspirin	Dyazide	Steroids	
Barbiturates	Erythromycin	Sulfa	
Benzodiazepines	HCTZ	Tetracycline	
Beta Blockers	Iodine	Tetanus	
Betadine	Lanoxin	Theophyllin	
Bronchodilators	Lidocaine	Thorazine	
Calcium Channel Blockers	Morphine	Toradol	
	Muscle Relaxers	Valproic Acid	Exit No-Save
	Nitrates	X-Ray Dye	Clear User
		Xylocaine	Exit

Figure Chapter 2: -7: Allergies

(Image: allergies.bmp)

A patient's known allergies may be entered for this visit and/or retrieved from previous visits to help avoid medication incidents in therapeutics, prescriptions or where nurses "take off orders." When a patient enters the emergency department alone or unconscious, your medical staff has the immediate advantage of getting this vital information from previous visits. Drug allergies are listed in red on screens where medications are ordered or prescribed.

Family And Social Histories

Social History

Active User J.E. Ross, MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 02

Sex	<input type="radio"/> Male	Marital	<input type="radio"/> Single	Lives With	<input type="radio"/> Spouse	Smoker?	<input checked="" type="checkbox"/> Cigarettes	Smoke Amount	<input type="radio"/> < 1/4 PPD
	<input checked="" type="radio"/> Female		<input checked="" type="radio"/> Married		<input checked="" type="radio"/> Spouse & Children		<input type="checkbox"/> Pipe		<input checked="" type="radio"/> 1/2 PPD
	<input type="radio"/> Unselected		<input type="radio"/> Divorced		<input type="radio"/> Adult Children		<input type="checkbox"/> Cigars		<input type="radio"/> 1 PPD
			<input type="radio"/> Widow(er)		<input type="radio"/> Minor Children		<input type="checkbox"/> Non-Smoker		<input type="radio"/> 2 PPD
			<input type="radio"/> Separated		<input type="radio"/> Parents				<input type="radio"/> > 2 PPD
			<input type="radio"/> Unselected		<input type="radio"/> Adult Roommate				<input type="radio"/> Unselected
					<input type="radio"/> Significant Other				
					<input type="radio"/> Alone				
					<input type="radio"/> Nursing Home				
					<input type="radio"/> Boarding Home				
					<input type="radio"/> Unselected				
Alcohol	<input type="checkbox"/> Beer	Alcohol Frequency	<input type="radio"/> < 1/Month	Drugs	<input type="checkbox"/> Amphetamines		<input type="checkbox"/> Narcotics		
	<input checked="" type="checkbox"/> Wine		<input type="radio"/> Monthly		<input type="checkbox"/> Barbiturates		<input type="checkbox"/> PCP		
	<input type="checkbox"/> Liquor		<input checked="" type="radio"/> Weekly		<input type="checkbox"/> Cocaine		<input type="checkbox"/> Other		
	<input type="checkbox"/> None		<input type="radio"/> Daily		<input type="checkbox"/> LSD		<input checked="" type="checkbox"/> None		
			<input type="radio"/> All Day		<input type="checkbox"/> Marijuana				
			<input type="radio"/> Unselected						
Double Click on Religion To Select									
<div> <div>Adventist</div> <div>African Meth. Episcopal</div> <div>Agnostic</div> <div>All Nations</div> <div>Anglican</div> </div>									
Religion: Catholic									
<div> <div>Admission</div> <div>Guarantor</div> <div>Insurance</div> <div>Employer/Contact</div> <div>Discharge</div> <div>Exit No-Save</div> <div>Clear User</div> <div>Exit</div> </div>									

Figure Chapter 2: -8: Social History

(Image: social-history.bmp)

Vital clues to a patient's condition may be available by accessing the family or social history. Regardless of who collects the information, it is available to the entire staff.

Lab Requests And Results

Labs Ordered - General			Active User: J.E. Ross, MD	
Patient Name: Garbo, Greta				
Adm #: 1895752		Pat #: 7564552		SS #: 450-81-9873
Bed: 02				
Show Labs Ordered			Requested by: J.E. Ross, MD	
General <input type="checkbox"/> CBC <input type="checkbox"/> Urinalysis <input type="checkbox"/> Blood Sugar <input type="checkbox"/> ABG's <input type="checkbox"/> Co-oximetry <input type="checkbox"/> Electrolytes <input type="checkbox"/> SMA 7 <input type="checkbox"/> SMA 13 <input type="checkbox"/> SMA 15 <input type="checkbox"/> SMA 20 <input type="checkbox"/> ER Panel <input type="checkbox"/> Cardiac Enzymes <input type="checkbox"/> Cardiac Isoenzymes <input type="checkbox"/> Liver Panel <input type="checkbox"/> Hepatitis Panel <input type="checkbox"/> Thyroid Panel <input type="checkbox"/> Serum Pregnancy <input type="checkbox"/> Urine Pregnancy Hematology <input type="checkbox"/> CBC <input type="checkbox"/> Sed Rate <input type="checkbox"/> PT <input type="checkbox"/> PTT	Chemistry <input type="checkbox"/> NA <input type="checkbox"/> K <input type="checkbox"/> Cl <input type="checkbox"/> CO2 <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Alkaline Phosphatase <input type="checkbox"/> SGOT (AST) <input type="checkbox"/> LDH <input type="checkbox"/> CPK <input type="checkbox"/> Rapid CPK-MB <input type="checkbox"/> Amylase, Serum <input type="checkbox"/> Bilirubin, Total <input type="checkbox"/> Ca <input type="checkbox"/> Mg <input type="checkbox"/> Total Protein <input type="checkbox"/> Cholesterol <input type="checkbox"/> Iron, Serum <input type="checkbox"/> Ammonia, Serum	Infectious Disease <input type="checkbox"/> Rapid Strep Screen <input type="checkbox"/> Monospot (Heterophile) <input type="checkbox"/> RPR <input type="checkbox"/> Serum HIV <input type="checkbox"/> Chlamydia Prep <input type="checkbox"/> Cervical GC Prep <input type="checkbox"/> HBsAg Drug Screens/Levels <input type="checkbox"/> Urine Drug Screen <input type="checkbox"/> Serum Drug Screen <input type="checkbox"/> Acetaminophen <input type="checkbox"/> Aspirin <input type="checkbox"/> Theophyllin <input type="checkbox"/> Digoxin Level <input type="checkbox"/> Alcohol, Serum <input type="checkbox"/> Dilantin Cultures/Micro <input type="checkbox"/> Throat C and S <input type="checkbox"/> Urine C and S <input type="checkbox"/> Blood C and S <input type="text"/> Minutes Apart <input type="checkbox"/> 1 Time <input type="checkbox"/> 1 Site <input type="checkbox"/> 2 Times <input type="checkbox"/> 2 Sites <input type="checkbox"/> Sputum C and S	Blood Bank <input type="checkbox"/> Type and Screen <input type="checkbox"/> Type and Cross <input type="text"/> Units Whole Blood <input type="checkbox"/> Crossmatched <input type="checkbox"/> Uncrossmatched Type Specific <input type="checkbox"/> Uncrossmatched Universal Donor <input type="checkbox"/> Packed Red Blood Cells (PRBCs) Lumbar Puncture <input type="checkbox"/> #1: C and S <input type="checkbox"/> #1: Gram Stain <input type="checkbox"/> #1: CIE's <input type="checkbox"/> #2: Protein <input type="checkbox"/> #2: Glucose <input type="checkbox"/> #3: Cell Count <input type="checkbox"/> #3: Differential	Other Labs <input type="button" value="Blood Bank"/> <input type="button" value="Chemistry"/> <input type="button" value="Cultures/Micro"/> <input type="button" value="Drug Scrns/Lev"/> <input type="button" value="General"/> <input type="button" value="Hematology"/> <input type="button" value="Infect Disease"/> <input type="button" value="Lumbar Punct"/> <input type="button" value="Spec Chem"/> <input type="button" value="Urine Chem"/> <input type="button" value="Exit No-Save"/> <input type="button" value="Clear User"/> <input type="button" value="Exit"/>

Figure Chapter 2: -9: Labs Ordered - General

(Image: labs-ordered.bmp)

When tests are required from the lab, radiology or another department in the hospital, orders may be entered and printed for these tests. Once results are available, the patient's record is updated and the screen indicates the completion. At a glance, you can tell what is still outstanding.

Therapeutics/Procedures

Burns

Active User J.E.Ross, MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 02

Requested by J.E.Ross, MD		Weight
Burn Wound Management <input type="checkbox"/> - <input type="checkbox"/> Sterile Sheets Applied <input type="checkbox"/> - <input type="checkbox"/> Cool Sterile Water Applied to Sheet <input type="checkbox"/> - <input type="checkbox"/> Cool Sterile Saline Applied to Sheet <input type="checkbox"/> - <input type="checkbox"/> Burn Cleansed w/Soap Solution <input type="checkbox"/> - <input type="checkbox"/> Silver Sulfadiazine Applied <input type="checkbox"/> - <input type="checkbox"/> Mafenide Acetate Applied <input type="checkbox"/> - <input type="checkbox"/> Polymyxin B, Bacitracin, Neomycin Ointment Applied <input type="checkbox"/> - <input type="checkbox"/> Non Adherent Burn Dressing Applied <input type="checkbox"/> - <input type="checkbox"/> Burn Left Open		<input type="checkbox"/> Estimated <div>129 lbs</div> <div>59 kg</div>
Airway/Oxygenation <input type="checkbox"/> - <input type="checkbox"/> Humidified O2 via Nasal Cannula at <div> </div> L/min <input type="checkbox"/> - <input type="checkbox"/> O2 via Venti Mask at <div> </div> % <input type="checkbox"/> - <input type="checkbox"/> O2 via Non-Rebreather at <div> </div> % <input type="checkbox"/> - <input type="checkbox"/> Racemic Epinephrine 0.3 cc via Nebulizer <input type="checkbox"/> - <input type="checkbox"/> Intubation w/ <div> </div> Fr ETT <input type="checkbox"/> - <input type="checkbox"/> FIO2 <div> </div> % <input type="checkbox"/> - <input type="checkbox"/> Tidal Volume <div> </div> cc <input type="checkbox"/> - <input type="checkbox"/> AC at <div> </div> /min <input type="checkbox"/> - <input type="checkbox"/> SIMV at <div> </div> /min <input type="checkbox"/> - <input type="checkbox"/> PEEP 5 cm H2O (For Pulmonary Edema)		Patient Instructions <input type="checkbox"/> Burn (General) <input type="checkbox"/> Burns of Face <input type="checkbox"/> Sunburn <input type="checkbox"/> Ultraviolet Precaution <div> <input checked="" type="checkbox"/> = Completed If checked, will not print instructions to perform. </div>
Pain/Anxiety Relief <div>Sedation/Analgesia</div>		
Fluid Resuscitation <input type="checkbox"/> - <input type="checkbox"/> Large Bore IV Inserted <input type="checkbox"/> - <input type="checkbox"/> IV: NS at <div> </div> ml/hr on Pump <input type="checkbox"/> - <input type="checkbox"/> IV: LR at <div> </div> ml/hr on Pump Parkland Formula $X = 4 \text{ ml/kg/\%} \times 1/2 \text{ (per first 8 hrs)/8 hrs} = 1/4 \times \text{wt in kg} \times \% \text{ TBSA burn}$ Example: if weight = 80 kg. and TBSA burn = 30%, then $X = 1/4 \times 80 \times 30 = 600 \text{ cc/hr}$		Tetanus Prophylaxis <input type="checkbox"/> - <input type="checkbox"/> Td 0.5 ml IM <input type="checkbox"/> - <input type="checkbox"/> TIG 250 u IM Carbon Monoxide Poisoning <input type="checkbox"/> - <input type="checkbox"/> 100% O2 via Non-Rebreather <input type="checkbox"/> - <input type="checkbox"/> Hyperbaric O2 Therapy
		<div>Exit No-Save</div> <div>Clear User</div> <div>Exit</div>

Figure Chapter 2: -10: Therapeutics - Burns

(Image: burns.bmp)

TeleMed permits rapid, thorough documentation of all procedures and therapeutics performed. It allows physicians to instantly generate printed nursing orders.

Prescriptions

Tetanus expired Pregnant Allergies Demerol sulfa

No.	Type	Route	Frequency	Duration
1/4	tab	po	1 time only	1 day
1/2	cap	pr	q day	2 days
3/4	inck	os	bid	3 days
1	lozenge	od	tid	4 days
2	ampule	ou	qid	5 days
3	packet	as	5 times daily	7 days
4	supp	ad	q 3*	10 days
5	piece	au	q 3-4*	12 days
6	implant	inhalations	q 3-6*	14 days
7	patch	intranasal	q 3-12*	21 days
8	bar	apply to affec. area	q 4*	28 days
9	bottle	topically	q 4-6*	30 days
10	qits	sublingual	q 4-8*	
	tsp	vaginal	q 5*	
<input type="checkbox"/> + 1/2	tbs	as irrigation	q 6*	
	cc	transdermal	q 6-8*	
	mcg	IM	q 6-12*	
	mg	IV	q 8*	
	gm	subcutaneous	q 8-12*	
	ml		q 12*	
	miu			
	mu			
	u			
	units			

☐ As Needed

To add 1/2 to the No. (i.e. 3-1/2)
click the box on "+ 1/2" then
click the appropriate No. button.

Drug Name

Keflet 500 MG

Generic

Cephalexin Tab

Drug Group

Drug Subgroup

Drug Class

Quantity Refills ☐ Refills PRNDuration DaysS16 (Use Option Return to
manually break lines)

1 tab po bid

☒ Selection Permitted☐ Dispense As Written

Print

Clear User

Exit

Figure Chapter 2: -11: Prescription Screen - Keflet

(Image: prescrip-keflet.bmp)

Writing prescriptions has never been easier or faster. You can select from your personal custom list of drugs, prescribing just the way you prefer, and with only three quick touches of the screen, your prescription is printed. Or you may expand your choices by entering the first few letters of the drug name, and TeleMed displays a comprehensive alphabetical listing. You can also view drugs by function classification to select the appropriate one. TeleMed lets you select or change the dosage, route, frequency and duration to fit the specific patient. Individual patient allergies are always displayed on the screen to avoid medication incidents.

Often patients fill their prescriptions away from the emergency department. Although instructions and warnings may be provided by the dispensing pharmacy, if someone other than the patient is getting the prescription filled, they may not have the same concerns or questions that the patient might. The prescription portion of the TeleMed system places the printed instructions in the patient's hands while they are still in the emergency department with staff members who know their condition and can answer their questions.

Referrals & Consultations

Refer To Active User J.E. Ross, MD

Patient Name Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Name

Specialty

Firm

Address

City, St, Zip

Office Phone

Appointment Date Appointment Time

Appointment In

Figure Chapter 2: -12: Referrals & Consultations

(Image: refer-to.bmp)

With TeleMed you can log all calls and conversations with primary or consulting physicians, so they become a permanent part of the patient's record. A full directory of physicians is available instantly. The physician directory includes referral patterns so you can go directly to the right doctor. When the patient is referred, the exit instructions show the doctor's name, specialty, office address, phone and even appointment date and time if one has been made.

The Medical Record

Patient Record Generator

Active User J.E. Ross, MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 02

A patient record containing patient information tracked by this program, including dictation, will be printed.

If a patient record has already been generated, it will be reprinted with the latest information.

Once the patient has been discharged and the Final Patient Record has been printed, the patient record will be locked and new updates permitted only with password release. This printed record will be marked "Final Patient Record."

Printing the Interim Patient Record will not lock the patient record, and the patient will remain on the "Record To Be Printed" list. This printed record will be marked "Interim Patient Record."

Print Nursing Record

Print Final Patient Record

Print Triage Record

Print Interim Patient Record

Print Dictation Record

Print Financial/Insurance

Clear User

Exit

Figure Chapter 2: -13: Patient Record Generator

(Image: patient-record-generator.bmp)

When you have completed your care, the medical record is printed out in a clear, readable, plain English sentence format as if you had dictated it.

The Medical Record (continued)

Editor - View Mode		Active User J.E.Ross, MD	
Patient Name Garbo, Greta			
Adm # 1895752	Pat # 7564552	SS # 450-81-9873	Bed 02
Dictator Ross MD			
Received //	Dictated 09/08/96 11:22		
Patient Verification			
Name Garbo, Greta	Text 1 of 1		
Adm # 1895752			
Pat # 7564552	History of Present Illness		
<p>This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.</p>			
			To Add Prior Next First Last Delete Edit Header
			Exit No-Save
			Clear User
			Exit

Figure Chapter 2: -14: Editor-View Mode

(Image: editor-view-mode.bmp)

If you wish to augment the record with dictation, TeleMed automatically integrates your dictation into the record.

Chapter 3: Getting Results With TeleMed

This chapter describes how to use TeleMed's data entry, retrieval and output functions.

TeleMed System Overview (All Users)

TeleMed System Security

The TeleMed system provides a security validation function. Personnel using the system must clearly demonstrate their identity using single and multiple passwords (ex. applying an electronic signature requires a second password) depending on the system configuration. The user's identity establishes the individual's "right" to use various functions. For example, physicians may be the only users given rights to generate prescriptions, nurses could have rights to implement various medical procedures, ward clerks might need rights to order labs, but records clerks may be limited to changing demographic information. After a certain period of inactivity, terminals revert to a "locked" status which requires re-entry of passwords, etc. in order to function.

Logging onto TeleMed

TeleMed is configured to automatically start up when any bedside workstation boots-up (starts-up). If TeleMed has been shut down or your workstation is not set to automatically start TeleMed on boot-up, TeleMed can be re-started by double clicking the TeleMed Desktop Icon or by selecting it from the "Start" Menu at the lower left of your screen.

If you have the TeleMed Smartcard Option:

TeleMed's Smartcard option allows users to quickly log in and out of TeleMed with a credit card like device on which is stored your username and opening password.

- To log into TeleMed, insert your personalized Smartcard in the reader slot. TeleMed will validate your username and password open to the Active Patient List in which you will see your ED's "grease board" (reference Figure Chapter 3: -2: Active Patient List (main tracking screen) Highlights).
- To log out of TeleMed, extract your Smartcard from the reader, the system would complete any remaining operations and close down to a protect screen or screen saver.

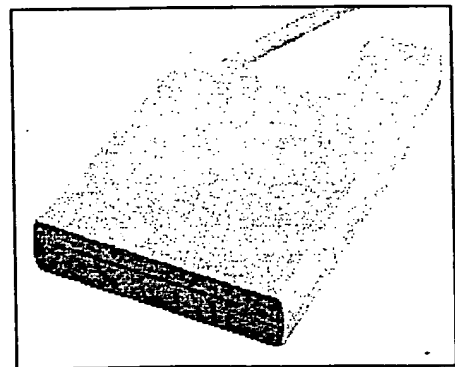


Figure Chapter 3: -1: Smart-card Reader

(Image: smartcard.bmp)

If you do not have the TeleMed Smartcard Option:

When TeleMed is started, it opens its Start-up Screen. If you are a registered user of TeleMed, your name will be placed on one of the user buttons. If you are required to use TeleMed and your name does not appear on this screen, contact your local TeleMed System Manager.

- To manually log into TeleMed, click on your name. You will be prompted for your password. Enter your password. TeleMed will validate your username and password then it opens the Active Patient List in which you will see your ED's "grease board" (reference Figure Chapter 3: -2: Active Patient List (main tracking screen) Highlights).
- To manually log out of TeleMed, click on the "Exit" button at the lower right corner of the TeleMed screen to save any information entered on the active screen and then click on the "Clear User" button located above the "Exit" button.

Page Intentionally Left Blank

TeleMed Main Tracking Screen

Active User: James Ross, Jr., MD

Active Patient List

Location	Name	Physician	Seen By	Orders	X-rays	Lab Tests	Dictates	Vitals	Priority	Elapsed Time
03	Alvarez, Byrd	Guerrero	P	N					4	
G5a	Garbo, Greta	J.E.Ross, MD	P	N	x	L			2	
R3b	Byrd, Biddie T		P	N					4	
R3c	Redford, Robert X	D.Foley, MD	P	N			d		1	
Unknown	Byrd, Fickle	J.F.Bragan, MD	P	P		I			4	
Unknown	Byrd, Newby	J.E.Ross, MD	P	N					1	

Medical Information

Outstanding Orders

Latest Vitals

Phone Directory

ED Layout

Waiting Patients

Patient Complaints

NonDictated

New Visit

Change

Patient History

Utilities

Clear User

1. Active User: James Ross, Jr., MD

2. Active Patient List

3. Patient Data Row

4. Patient Data Row

5. Patient Data Row

Figure Chapter 3: -2: Active Patient List (main tracking screen) Highlights

(Image: tm-2.bmp)

The “Active Patient List” provides you with quick access to a high level summary of your Emergency Department’s current state. It is your Emergency Department’s “main tracking screen” through which TeleMed helps you manage your ED.

It quickly answers the question: “What is happening in your ED?”

I.E...

- Who is here?
- Who is next?
- What are their vitals?
- Who should be made next?
- Where are they?
- How do I get there?

This "Active Patient List" screen performs five functions:

1. Identifies the "Active User" (upper tight corner of screen) logged into TeleMed at this workstation. This person should be you.
2. Provides a "Grease Board" listing:
 - Patient Location (within Emergency Department)
 - Patient Name
 - Attending Physician
 - Patient Priority
 - Color Coded Patient Order Status (refer to the following Grease Board Color Codes)
3. Provides access to clinician and patient information functions (right side of screen, buttons: "Medical Information" through "Patient History").
4. Provides access to System Management "Utilities" (right side of screen).
5. Provides user log-out function (lower right button: "Clear User").

Clicking on any button, other than the "Utilities" and "Clear User" buttons, will allow you to review, enter or modify patient information.

The "Clear User" button will log you out of TeleMed.

Clicking on the "Utilities" button will allow those with System Manager privileges to:

- Edit, add or delete users
- Edit the doctor drug prescription preference list
- Edit doctor drug order preferences (medications ordered to be given in ED)
- Edit Prephrased text

Grease Board Color Codes

- Black letters on Yellow -- No Alert
- Black letters on White -- Ordered
- White letters on Green -- Partially Filled or Back
- White letters on Peach -- Late
- White letters on Red -- Alert, Action Required
- White letters on Black -- All Are Filled or Back

TeleMed Main Patient Information Screen

Active User James Ross, Jr., MD

Patient Name Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-01-9873 Bed 07A

Medical Information		Priority 2	Location 07A	Print Medical Record	Seen By Nurse
INPUT		HISTORICAL			Seen By Doctor
Triage	Vital Signs	Summary			Record Dr. Interval
Complaint	Progress Notes	Vital Signs			Phone Directory
Differential Diagnosis	Lab Requests	Prog. Notes Summary			Department Clerk
Diagnosis	Radiology Requests	Lab Results			Patient Instructions
Prephrased Text	Test Requests	EKG Results			Work Excuse
Review of Systems	Diagnostic Procedures	Transcript Editor			School Excuse
Allergies	Therapeutics	Therapeutics Summary			Patient Questionnaire
Past Medical History	Medications in ER	Prescribed Meds			Physician
Family History	Prescriptions	Consultation Log			Employer/Contact
Social History	Consultations	Referral Log			Admission
	Referrals	Dr. Interval			Discharge
					Clear User
					Exit

Figure Chapter 3: -3: Medical Information (main patient information screen)

(Image: medical-info.bmp)

The Medical Information screen displays the full range of TeleMed options, from entering complaints and diagnoses to writing prescriptions or printing work excuses, with which to medically document your patient.

Please note, there are 2 sides to the Medical Information screen.

One area is **INPUT**. All of the buttons in this section/box are for you to enter information in the patient's chart.

The other side is **HISTORICAL**. The buttons in this section/box allow you to review information entered in the patient's chart.

With a single touch of the screen, you can move painlessly through other screens to:

- capture a patient's history, enter vital signs, prescribe medications or give orders to others
- access/review recent and past patient's summaries, vitals, therapeutics, consultations and referrals.

Treat this as your main patient information screen.

It quickly answers "What is happening with your patient?"

General TeleMed Usage (All Users)

Mouse & Keyboard

Using a mouse is usually easier and quicker than using a keyboard. Because of this, most procedures accomplished via TeleMed are done with a mouse (or touch screen if you have purchased that option).

Whenever you are instructed to **“Click”** on a TeleMed item/function, you will place the tip of the screen pointer of your mouse over that item and quickly press and release the left mouse button. Whenever you are instructed to **“Double-click”** on an item, you will place the tip of the screen pointer of your mouse over that item and “click” the left mouse button twice in rapid succession.

Keyboard usage is limited to the entering & deleting text in form fields (dialogue boxes) provided within TeleMed.

Touch Screen (optional)

With the Touch Screen option, users should equate **“Click”** to **“One Touch”** and **“Double-click”** to **“Two Touches”** in rapid succession.

Navigating / Changing Screens

TeleMed offers four methods to navigate (or change) to/from function screens. All navigation is performed via on screen buttons:

<p>1. Specific function buttons</p> <p>Examples</p>	<div style="display: flex; flex-wrap: wrap; justify-content: space-around;"> <div style="border: 1px solid black; padding: 2px; margin: 2px;">New Patient</div> <div style="border: 1px solid black; padding: 2px; margin: 2px;">Diagnosis</div> <div style="border: 1px solid black; padding: 2px; margin: 2px;">Triage</div> <div style="border: 1px solid black; padding: 2px; margin: 2px;">Complaints</div> <div style="border: 1px solid black; padding: 2px; margin: 2px;">Print Triage Record</div> </div> <p>These buttons can be located anywhere on the screen.</p>
<p>2. Exit without saving information modified on this screen (but remain logged-in)</p>	<div style="border: 1px solid black; padding: 2px; margin: 2px; text-align: center;">Exit No-Save</div> <p>This button is located at lower right corner of the screen.</p>
<p>3. Log out and save information modified on this screen (“Clear User” always saves).</p>	<div style="border: 1px solid black; padding: 2px; margin: 2px; text-align: center;">Clear User</div> <p>This button is located at lower right corner of the screen.</p>
<p>4. Exit and save information modified on this screen</p>	<div style="border: 1px solid black; padding: 2px; margin: 2px; text-align: center;">Exit</div> <p>This button is located at lower right corner of the screen.</p>

Using Menus

TeleMed utilizes three information menu option methods within its interface: Check box, Lists and Pull Downs. The following describes each.

Using Check box Menus

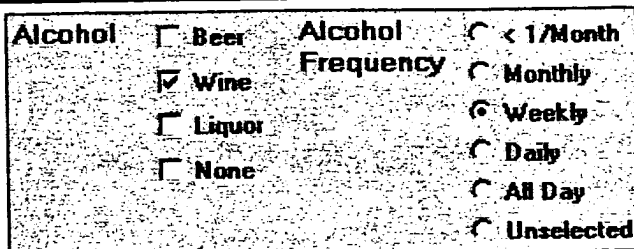


Figure Chapter 3: -4: Check box Menu

(Image: checkbox-menu.bmp)

This figure is an example of a checklist type menu. This type of menu allows the user to select multiple options, from one screen, simultaneously. Click on any check box will insert (or remove) a "✓" or "•" mark within the check box.

Some check boxes are used when only one of the listed menu options can be selected (ex. Alcohol Frequency).

Using List Menus

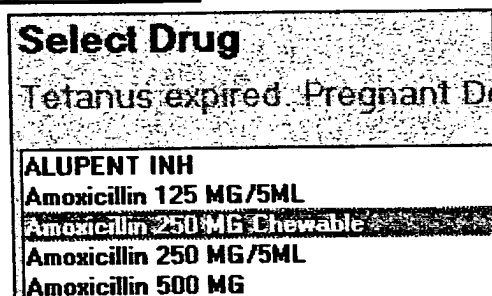


Figure Chapter 3: -5: List Menu

(Image: list-menu.bmp)

This figure is an example of a simple list type menu. This type of menu allows the user to select a single item (in this case a patient) for which additional activity will be based upon (triage, complaints, diagnosis etc.). Sometimes double clicking on a list menu item will trigger a default additional activity.

Using Pull Down Menus

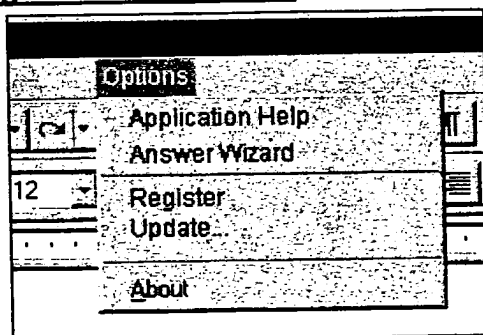


Figure Chapter 3: -6: Pull Down Menu

(Image: pull-down-menu.bmp)

This figure is a pull down (or Windows) menu that appeared when the menu bar option "Help" was selected. To open a pull down menu:

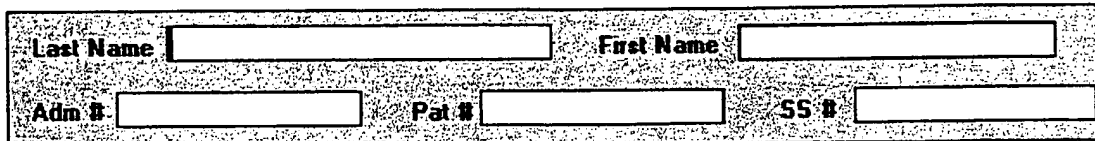
1. Move the mouse pointer so that it points to the name of the menu, and then click the left mouse button. This will pull the menu down.
2. Once the menu has been selected, click the menu item you want.

TeleMed uses very few of these.

Entering & Deleting Text In Form Fields (Dialogue Boxes)

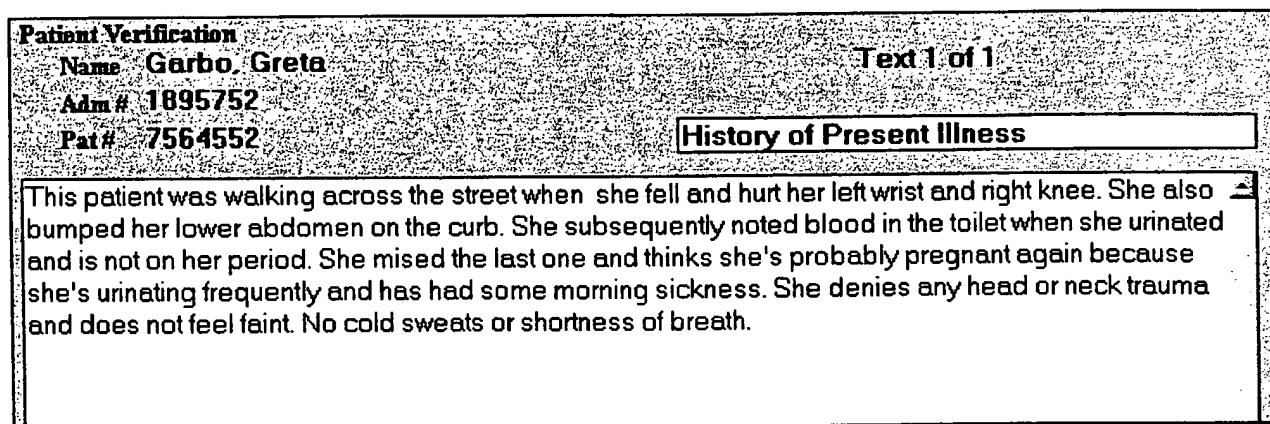
The following screens are examples of the two types of form fields used in TeleMed.

The first sample of form fields (Last Name, Adm. #, etc) are examples of single line form fields. The second sample is an example of a multiline form field as used in "Edit View Mode".



A screenshot of a form with five single-line input fields. The fields are labeled: Last Name, First Name, Adm #, Pat #, and SS #. Each label is followed by a rectangular text box.

(Image: form-field1.bmp)



A screenshot of a "Patient Verification" form. It displays patient information: Name Garbo, Greta; Adm # 1895752; Pat # 7564552. To the right, it says "Text 1 of 1". Below this is a section titled "History of Present Illness" with a large text area containing the following text: "This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath."

Figure Chapter 3: -7: Typical Form Fields

(Image: form-field2.bmp)

TIPS:

- Before you can enter text in a form field, make sure it is made active by placing your mouse pointer over the field and clicking your mouse once. An active field will have a blinking "I" vertical cursor in it.
- Using the "Tab" key to switch between form fields allows you to work with just the keyboard and not have to switch to your mouse to move to another form field.

Printing

Medical records are sent to your local printer when the "Print Medical Record" button is selected in the Medical Information screen (refer Figure Chapter 1: -1, just above HISTORICAL field). The "Print Medical Record" button will open TeleMed's "Patient Record Generator" screen from which you can print the following:

- Nursing Record
- Triage Record
- Dictation Record
- Financial/Insurance Record
- Final Patient Record
- Interim Patient Record

TeleMed Tracking System (All Users)

Overview

TeleMed assists you with managing your ED. The hub of these tasks is the “Active Patient List” screen. This section will focus on the ED tracking / management functions.

Alerts and Checks

TeleMed provides “medical condition” alerts and automatically places these where pertinent. For example x-ray orders on pregnant women include a “shield abdomen” warning. Drug allergies are listed in medication ordering and administration sections.

The following graphical symbols are used:

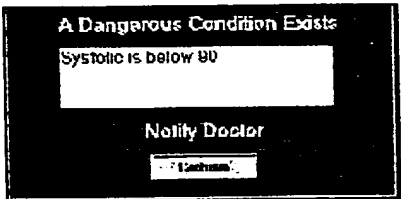
Symbol	Description	Usage
✓	Red Check	Used to indicate that this TeleMed function <u>has not been</u> opened for this patient and no data has been entered
◆	Red Diamond	Used to indicate that this TeleMed function <u>has been</u> opened for this patient. Once opened, the user can opt to not enter data and the diamond will appear upon exit
 (Image: alert-icon.bmp)	Red Screens	A red screened window will pop up when certain type data is entered that requires immediate attention. Example: Vital signs are entered that are outside a specified “acceptable” range (ex. BP=50/20). Upon exiting the Vitals screen, a red pop-up window will open alerting the user to immediately contact a doctor

Table Chapter 3: -1: Alerts and Checks

Calling Up the "Grease Board"

1. Log into TeleMed (refer to Logging onto TeleMed, page 29) to open the "Active Patient List". The "Grease Board" is located on this screen.

Active Patient List										Active User: James Ross, Jr., MD	
Location	Name	Physician	Seen By	Order	X-ray	Lab	Test	Dictate	Vitals	Patient	Plat
03	Alvarez, Byrd	Guerrero	P	N					4		
G5a	Garbo, Greta	J.E.Ross, MD	P	N	x	L			2		
R3b	Byrd, Biddie T		P	N					4		
R3c	Redford, Robert X	D.Foley, MD	P	N				d	1		
Unknown	Byrd, Fickle	J.F.Bragan, MD	P	P		I	d		4		
Unknown	Byrd, Newby	J.E.Ross, MD	P	N					4		

Medical Information
Outstanding Orders
Latest Vitals
Phone Directory
ED Layout
Waiting Patients
Patient Complaints
NonDictated
New Visit
Change
Patient History
Utilities
Clear User

Figure Chapter 3: -8: Active Patient List

(Image: tm-2.bmp)

Medical Information

- 2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

- 2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Alternate access to this screen:

- Patient Order List or Patient Complaint List

Viewing Patients on the ED Graphic Layout

From the "Active Patient List" (your main tracking screen):

ED Layout

1. Click the Ed Layout button.

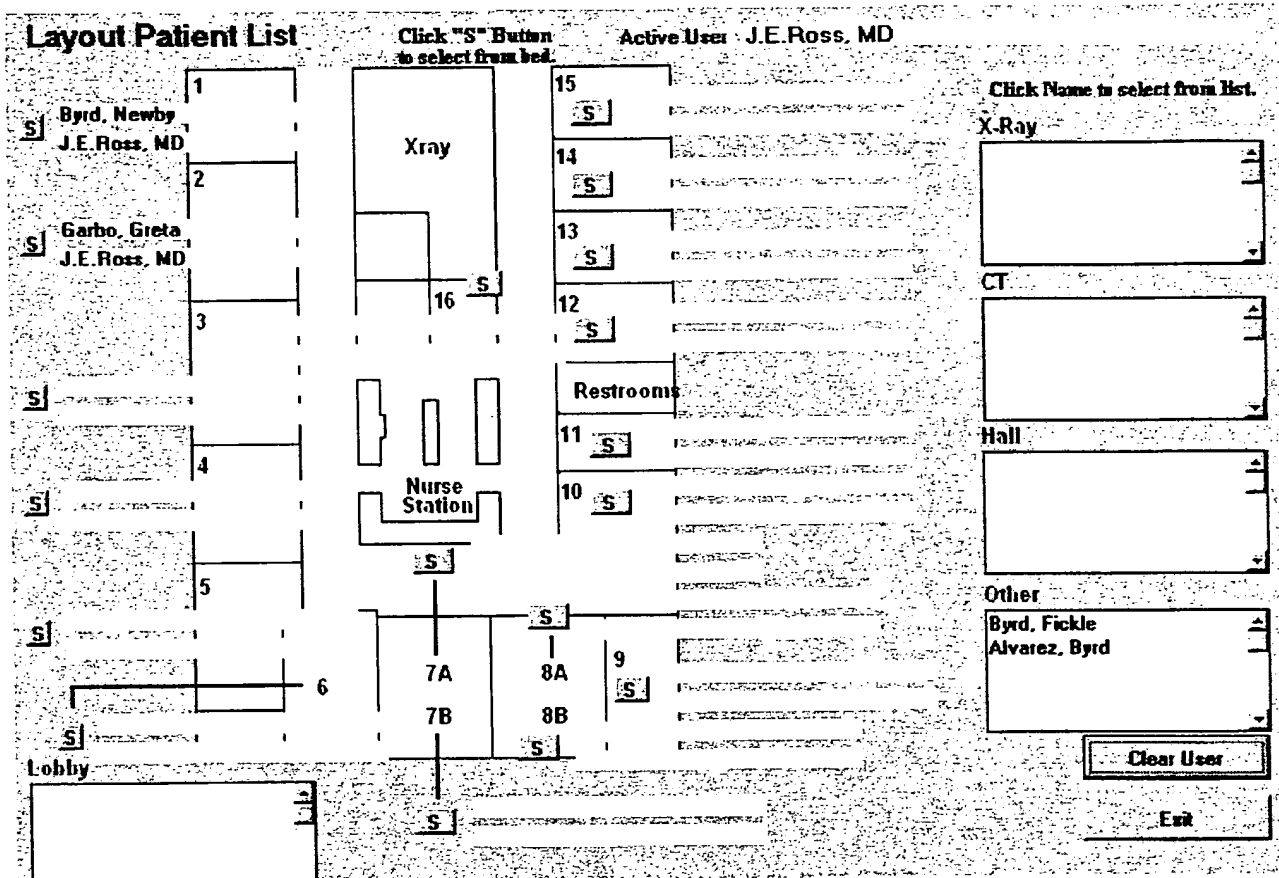


Figure Chapter 3: -9: Layout Patient List

(Image: layout-patient-list.bmp)

S

2a. Click the S button next to the patient who's information you wish to update.

or

2b. Double Click the name you wish to update in the listed menus (Lobby, X-Ray, CT, Hall, Other).

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Alternate access to this screen:

- Patient Order List or Patient Complaint List

Viewing Patients In the ED by Complaint

From the "Active Patient List" (your main tracking screen):

Patient Complaints

1. Click the Patient Complaints button.

Physician	Name	Location	Complaint
J.E. Ross, MD	Newby Byrd	81	Fever
J.E. Ross, MD	Greta Garbo	82	Fall
J.E. Ross, MD	Fickle Byrd	Lobby	Hypertension

Active User: J.E. Ross, MD

Buttons on the right: Medical Information, Phone Directory, ED Layout, Active Patients, Clear User, Exit.

Figure Chapter 3: -10: Patient Complaint List

(Image: patient-complaint-list.bmp)

Medical Information

2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Viewing Patients In the ED Waiting to be Seen by the Doctor

From the "Active Patient List" (your main tracking screen)

Waiting Patients

1. Click the Waiting Patients button.

Patient Order List Active User: J.E. Ross, MD

Order	Location	Admission #	Name
4-	Lobby	P000002405	Byrd, Fickle
4-	Unknown	U86505016	Alvarez, Byrd

Medical Information

Phone Directory

ED Layout

Active Patients

Clear User

Exit

Figure Chapter 3: -11: Patient Order List

(Image: patient-order-list.bmp)

Medical Information

- 2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.
- or
- 2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Viewing Dictation Status of Patients In the ED

From the "Active Patient List" (your main tracking screen)

NonDictated

1. Click the NonDictated button.

Physician	Name	Adm #	Pat #	Date/Time
J. E. Ross, MD	Fickle, Byrd	P000002405	G16534459	12/09/96

Medical Information

Clear User

Exit

Figure Chapter 3: -12:Recent Patient Without Dictation

(Image: recent-patient-without-dictation.bmp)

Medical Information

2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Viewing Outstanding Orders on Patients In the ED

From the "Active Patient List" (your main tracking screen)

Latest Vitals

1. Click the Outstanding Orders button.

Outstanding Orders Active User: J.E. Ross, MD

Location	Adm #	Name	Date	Time	Ordered By
04	K226534752	Smith, John	11/22/96	14:59	A.O. Kay MD
02	K226534765	Jones, Ken	11/22/96	15:05	H.A. You MD
01	K226534749	Byrd, Newby	11/22/96	14:54	J.E. Ross MD
03	K226534755	Garbo, Greta	11/22/96	15:10	M.H. Jensen MD
11	K226534753	Ford, Joe	11/22/96	14:54	J.E. Ross MD

Orders are removed in Progress Notes under a specific patient.

Clear Uses

Exit

Figure Chapter 3: -13: Outstanding Orders

(Image: outstanding-orders.bmp)

Adding New Patients

Entering a New Patient Visit

From the "Active Patient List" (your main tracking screen)

New Visit

1. Click the New Visit button.

Active User J.E. Ross, MD

Last Name First Name MI Generation

Adm # Pat # SS # DOB

Enter the name or enter one of the patient numbers (hyphens in SS# are optional).
 Click "Check Previous" if patient has previously visited the ED, select patient (double click).
 If patient has not visited the ED, enter all available information.
 Click "New Visit"

Clear Patient

Check If Previous Patient

Clear User

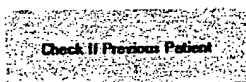
Exit

Linking #

Figure Chapter 3: -14: New Visit (Patient) Entry Screen

(Image: new-visit1.bmp)

3. Enter the patient's First Name, Last Name, Middle Initial, Generation and Date of Birth (DOB).
4. Click on the Check if Previous Patient button. TeleMed will search for any previous visits by this patient that were logged into TeleMed.



Entering a New Patient Visit ---- Previous Visit Entry Found

- 5a. If previous visits are found, double click on the correct visit to complete the patient number (and any missing name information).
 6a. Click on the New Visit button

TeleMed will now bring you to the Medical Information screen

Active User: J.E. Ross, MD

Last Name: First Name: MI: Generation:

Adm #: Pat #: SS #: DOB:

Enter the name or enter one of the patient numbers (hyphens in SS# are optional)
 Click "Check Previous", if patient has previously visited the ED, select patient (double click).
 If patient has not visited the ED, enter all available information.
 Click "New Visit"

Clear Patient

Name	DOB	Pat #	Last Discharge

New Visit

Clear User

Linking #
P000022317

Exit

Figure Chapter 3: -15: New Visit (Patient) Entry Screen after previous visit has been selected

(Image: new-visit2.bmp)

Entering a New Patient Visit ---- No Previous Visit Entry Found



5b. If no previous visits were logged into TeleMed, the name list will remain blank.

6b. Click the Select Previous or New Patient button

Active User: J.E. Ross, MD

Last Name: First Name: MI: Generation:

Adm #: Pat #: SS #: DOB:

Enter the name or enter one of the patient numbers (hyphens in SS# are optional)
 Click "Check Previous" if patient has previously visited the ED, select patient (double click)
 If patient has not visited the ED, enter all available information.
 Click "New Visit"

Name	DOB	Pat #	Last Discharge

Linking #

Buttons: Clear Patient, Select Previous or New Patient, Clear User, Exit

Figure Chapter 3: -16: New Visit (Patient) Entry Screen

(Image: new-visit3.bmp)

7. TeleMed will now bring you to the Medical Information screen.

Tips and Hints: Adding New Patients

- There is no need to capitalize the first letters of names or initials. TeleMed will capitalize these letters automatically.
- When entering date of birth (DOB) year information, TeleMed will automatically interpret 70 as 1970.
- The Select Previous or New Patient button can be used after entering just the last name of a patient. Note, the search results may provide a lengthy list of past patients that share the same last name. Additional name information (first name, middle initial, generation and date of birth) will provide a more concise search.

Moving Patients to Different Location

From the "Active Patient List" (your main tracking screen)

Medical Information

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Info button.
3. Click the Location pull down menu and select new location.

Active User: James Ross, Jr. MD

Patient Name: Byrd, Fickle
Adm #: G16534459 Pat #: 16548 SS #: Bed: Unknown

Medical Information		Priority: 4	Location: Unknown	Print Medical Record	Not Seen By Nurse Seen By Doctor
INPUT		HISTORICAL			
Triage	Vital Signs	Unknown	Summary	Record Dr. Interval	
Complaint	Progress Notes	Lobby	Vital Signs	Phone Directory	
Differential Diagnosis	Lab Requests	01	Prog. Notes Summary	Department Clerk	
Diagnosis	Radiology Requests	02	Lab Results	Patient Instructions	
	Test Requests	06	EKG Results	Work Excuse	
Prephrased Text	Diagnostic Procedures	07B	Transcript Editor	School Excuse	
Review of Systems	Therapeutics	08A	Therapeutics Summary	Patient Questionnaire	
Allergies	Medications in ER		Prescribed Meds	Physician	
Past Medical History	Prescriptions		Consultation Log	Employer/Contact	
Family History	Consultations		Referral Log	Admission	
Social History	Referrals		Dr. Interval	Discharge	
				Clear User	
				Exit	

Figure Chapter 3: -17: Changing Patient Location

(Image: med-info-location.bmp)



4. Click the Exit button to save updated patient information.

Changing Acuity of Patients

From the "Active Patient List" (your main tracking screen)

Medical Information

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click the Priority pull down menu and select priority.

Active User James Ross, Jr. MD

Patient Name Byrd, Fickle Adm # G16534459 Pat # 16548 SS # Bed Unknown

Medical Information		Priority	Location	Print Medical Record	Not Seen By Nurse Seen By Doctor
INPUT		<div style="border: 1px solid black; padding: 2px;"> 1 2 3 4 </div>	Unknown		
Triage	Progress Notes			Summary	Record Dr. Interval
Complaint	Lab Requests			Vital Signs	Phone Directory
Differential Diagnosis	Radiology Requests			Prog. Notes Summary	Department Clerk
Diagnosis	Test Requests			Lab Results	Patient Instructions
Prephrased Text	Diagnostic Procedures			EKG Results	Work Excuse
Review of Systems	Therapeutics			Transcript Editor	School Excuse
Allergies	Medications in ER			Therapeutics Summary	Patient Questionnaire
Past Medical History	Prescriptions			Prescribed Meds	Physician
Family History	Consultations			Consultation Log	Employer/Contact
Social History	Referrals			Referral Log	Admission
				Dr. Interval	Discharge
					Clear User
					Exit

Figure Chapter 3: -18: Changing Patient Priority (acuity)

(Image: med-info-priority.bmp)

Exit

4. Click the Exit button to save updated patient information.

Modifying Patient Tracking Numbers

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Change button.

Change

Active User: J.E. Ross, MD

Last Name: First Name: MI: Generation:

Adm #: Pat #: SS #: DOB:

To find a patient enter one of the patient numbers (hyphens in Social Security Number are optional) or the last and first name (or part of the last name).
Click "Find Patient"

Clear Patient

Date	ADM #	Complaint
02/10/97	B107378119	

Select Visit

CHANGE PATIENT
Change patient information and click "Change"

Change

Medical Info.

Clear User

Linking #
B107378119
N107378116

Exit

Figure Chapter 3: -19: Modifying Patient Tracking Number

(Image: change-pat-no.bmp)

3. Modify (edit) the number in the Patient Tracking number field.
4. Click the Change Button on this Screen.
5. Click the Exit button to save updated patient information.

Change

Exit

Looking Up Previous Emergency Visits

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Patient History

3. Click on the Patient History button at the right of screen. (all prior visits to the ED will be listed)

Active User J.E. Ross, MD

Last Name First Name MI Generation

Adm # Pat # SS # DOB

To find a patient enter one of the patient numbers (hyphens in Social Security Number are optional) or the last and first name (or part of the last name). Click "Find Patient"

Date	ADM #	Complaint
12/10/96	K226534749	fever
10/01/96	K208473622	sinus pain
03/12/94	D384663524	broken arm

Linking #
K226534749
W226534746

Figure Chapter 3: -20: Previous Emergency Visits

(Image: patient-history-cr0358.bmp)

5. Double-click on the visit desired

Medical Information

6. Click on the Medical Info. button. (At this point, you are brought to the Medical Information Screen for the selected past ED visit.)

Click on the Summary button to review the record of that visit. (page 218)

Click on the Print Medical Record button then Print Interim Patient Record for a printout of the previous visit. (page 37)

Patient Information

Adding Patient Demographic Information (Name, Address Etc.)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Admission

3. Click on the Admission button at the right of screen.

Admission Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Patient ☐ VIP

Social Security #: 450-81-9873 Arrived At ED
Date: 12/09/1996
Time: 09:11 A

Local Address: 2332 Main Street Mode of Arrival
☒ Ambulatory
☐ Wheelchair
☐ Carried
☐ Ambulance
☐ EMS
☐ Unselected

City: San Antonio State: TX Zip: 78209

Permanent Address: 885 Hyde Park Circle

City: Houston State: TX Zip: 77054

Local Phone: (210)493-1727 Permanent Phone: (210)377-3366

Sex: ☐ Male ☒ Female ☐ Unselected Marital: ☐ Single ☒ Married ☐ Divorced ☐ Widow(er) ☐ Unselected

Birthdate: 09/21/1958 Race: Caucasian Patient Type: ☒ Emergency ☐ Inpatient ☐ Outpatient ☐ Unselected

Age: 38 Years

Religion: Catholic

Double Click on Religion To Select

Adventist
 African Meth. Episcopal
 Agnostic
 All Nations
 Anglican
 Apostolic
 Assemblies of God
 Atheist
 Baptist
 Bible

Patient Status: Emergency Active
 Financial Class: Blue Cross

Accident
☒ Yes ☐ No ☐ Unselected
☐ Job Related Indicator:

Accident Date: 09/08/1996 A Time: 07:43

Social History
Guarantor
Insurance
Employer/Contact
Discharge
Exit No-Save
Clear User
Exit

Figure Chapter 3: -21: Admission

(Image: admission.bmp)

4. Click on check boxes and form fields to complete as appropriate.

NOTE: The DUP button allows you to duplicate the Local Address in the Permanent Address fields. The A button will automatically insert the actual (current) time and date.

Exit

5. Click the Exit button to save updated patient information.

Adding Guarantor Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Admission

3. Click on the Admission button at the right of screen.

Guarantor

4. Click on the Guarantor button at the right of screen.

Guarantor Active User J.E.Ross, MD

Patient Name Jones, John J Jr
 Adm # B277366719 Pat # B277366719 SS # 123-45-6789 Bed Unknown

Name **Guarantor Patient**
 Address
 City State Zip
 Home Phone Sex ☒ Male
 SS # ☐ Female
 Relation ☐ Unknown

Guarantor Employment

Name
 Address
 City State Zip
 Work Phone

Admission
 Guarantor
 Insurance
 Employer/Contact
 Discharge
 Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -22: Guarantor

(Image: guarantor.bmp)

4. Click on check boxes and form fields to complete as appropriate.

NOTE: The Guarantor Patient button allows you to duplicate the Permanent Address fields from the Admission screen.

Exit

5. Click the Exit button to save updated patient information.

Adding Insurance Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Admission

3. Click on the Admission button at the right of screen.

Insurance

4. Click on the Insurance button at the right of screen.

Insurance Plan 1 Active User: J.E. Ross, MD

Patient Name: Byrd, Newby
 Adm #: K226534749 Pat #: K226534749 SS #: Bed: 01

Plan Name: Blue Cross of TX	Code: B01	Insurance Plans Blue Cross of TX Bankers Life Benefit Planners Blue Cross Fed Blue Cross OOS Blue Cross of TX CNA/SW Employee CPS Group Health
Policy #:	Group #:	
Mail To: Blue Cross of TX		
Address 1: P.O. Box 660044		
Address 2:		
City: Dallas	State: TX	Zip: 75266
Phone: 214-669-0082	Treatment Phone:	
Authorization #:	<input type="checkbox"/> Verified	
Subscriber:	Self	
SS #:	Birth Date: //	Edit Ins. Plans Admission Social History Guarantor Employer/Contact Discharge Exit No-Save Clear User Exit
Employer ID:	Relation:	
Financial Class:		
Comments:		

Figure Chapter 3: -23: Insurance Plan (1)

(Image: insurance-plan-1.bmp)

4. Click on check boxes and form fields to complete as appropriate.
 NOTE: The Insurance Plans pull down menu lists all current insurance plans which have been entered in TeleMed. Selecting one of these will automatically load most of the fields. Click on the Edit Ins. Plans button to add new/modify plans.
 The Self button allows you to duplicate any appropriate patient's information currently loaded in the Admission screen.

Exit

5. Click the Exit button to save updated patient information.

Adding Employer/Contact Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Employer/Contact

3. Click on the Employer/Contact button at the right of screen.

Employer/Contact Active User J.E.Ross, MD

Patient Name Jones, John J Jr
 Adm # B277366719 Pat # B277366719 SS # 123-45-6789 Bed Unknown

Employer

Address:

City State Zip

Employee Occupation

Work Telephone

Employee Supervisor

Local Contact/Nearest Relative

Name

Address

City State Zip

Work Telephone Home Telephone

Relation

Admission

Social History

Guarantor

Insurance

Discharge

Exit No-Save

Clear User

Exit

Figure Chapter 3: -24: Employer/Contact

(Image: employer-contact.bmp)

4. Click on form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Assigning/Changing ED Physician

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Physician

3. Click on the Physician button at the right of screen.

Patient ED Physician Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 07A

Last Visit: / /

ED Physician: ☐ Dictation Outstanding

The automatic button ("A") will assign the Active User as the ED Physician.

Assign ED Physician

☐ Simulated Patient

Figure Chapter 3: -25: Patient Ed Physician

(Image: patient-ed-physician.bmp)

4. Click on form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Tips and Hints: *Patient Information:*

- There is no need to capitalize a patient's first letters or initials. TeleMed will capitalize these letters automatically.
- Any of the following screens provides access to each other:

Admission

Discharge

Employer/Contact

Guarantor

Insurance

Social History

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Discharging, Admitting or Transferring Patients from the ED

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Discharge

3. Click on the Discharge button at the right of screen.

Discharge Active User: J.E. Ross, MD

Patient Name: Smith
 Adm #: B107378119 Pat #: B107378119 SS #: Bed: Unknown

Released From ED By: A

Discharge Condition

☐ Good ☐ Improved
☐ Fair ☐ Stable
☐ Poor ☐ Unstable

Patient Expired

☐ Patient Expired
 Date: / /
 Time:

Admit To Hospital ☐ Admitted to ICU
☐ Admitted to Hospital ☐ Sent to Outpatient/OR
☐ Admitted 23 Hr Obs ☐ Admitted to Maternity Unit

Admission Date: / /
 Admission Time:
 Admitted To Doctor:

Released From ED

Date: / / A
 Time:

☐ Discharged
☐ Transferred
☐ Managed Care Denial
☐ Left Without Being Registered
☐ Left Without Seeing Physician
☐ Left Before Receiving Instructions
☐ Refused Admission
☐ Left Against Medical Advice

ED Physician:

Assign ED Physician:

☐ Bed Was Used

☒ Active Patient
☐ Inactive Patient, Hold To Complete Record
☐ Hold Room For Cleaning
☐ Inactive Patient (Removes From Listing)

Admission

Social History

Guarantor

Insurance

Employer/Contact

Exit No-Save

Clear User

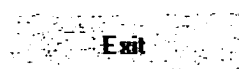
Exit

Figure Chapter 3: -26: Discharge

(Image: discharge.bmp)

4. Click on check boxes and form fields to complete as appropriate.

NOTE: The A button will automatically insert the actual date and time in the "Released From ED" or your name in "Release From ED By" sections.



5. Click the Exit button to save updated patient information.

TeleMed Triage (Nurses)

Entering/Modifying Triage Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.

Medical Information

Triage

Click on the Triage button in the INPUT section.

Triage/Medical Screening - Intro Active User: James Ross, Jr., MD

Patient Name: Byrd, Fickle Adm #: G16534459 Pat #: 16548 SS #: Bed: Unknown

Sex: ☐ Male Birthdate: as 00/00/0000 Home Phone #:
☒ Female Birthdate: 2/19/77
☐ Unselected Age: 19 Years Work Phone #:

Race: Purpose:
 History/Asses:
 Determination:

Arrived At ED
 Date: 01/13/1997
 Time: 11:08

Mode of Arrival: ☐ Ambulatory
☐ Wheelchair
☐ Carried
☐ Ambulance
☐ EMS
☒ Unselected

Triage Summary:
 Print Triage Record:
 Exit No-Save:
 Clear User:
 Exit:

Figure Chapter 3: -27: Triage/Medical Screening - Intro

(Image: triagemed-screen-intro.bmp)

4. Click on check boxes and form fields to complete as appropriate.

Entering/Modifying Triage Information (continued)

History/Asses

7. Click the History/Asses. button to continue entering patient information.

Triage/Medical Screening - History/Assessment Active User: James Ross, Jr. MD

Patient Name: Byrd, Fickle Adm # G16534459 Pat # 16548 SS # Bed: Unknown

<p>Current Meds</p> <p><input type="button" value="Not Available"/></p> <p><input type="button" value="None"/></p> <p>Previous Meds</p> <p><input type="button" value="Not Available"/></p> <p><input type="button" value="None"/></p>	<p>LMP <input type="button" value="Pregnant"/></p> <p><input type="text"/></p> <p>EDC</p> <p><input type="text" value="//"/></p> <p>Gestation</p> <p><input type="text"/> Wks.</p>	<p>Pregnancies (total)</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 or More</p> <p>Births (previous)</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 or More</p> <p>Abortions Spontaneous</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 or More</p> <p>Abortions Therapeutic</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 or More</p>	<p>Informant</p> <p><input type="text"/></p> <p>Intro</p> <p><input type="button" value="Purpose"/></p> <p><input type="button" value="Allergies"/></p> <p><input type="button" value="Past Med History"/></p> <p><input type="button" value="Social History"/></p> <p><input type="button" value="Vitals"/></p> <p><input type="button" value="Assessment"/></p> <p><input type="button" value="Determination"/></p> <p><input type="button" value="Exit No-Save"/></p> <p><input type="button" value="Clear User"/></p> <p><input type="button" value="Exit"/></p>									
<p>Treatment Prior To Arrival</p> <p><input type="checkbox"/> None <input type="checkbox"/> Sling</p> <p><input type="checkbox"/> C-Collar <input type="checkbox"/> Splint</p> <p><input type="checkbox"/> Backboard <input type="checkbox"/> Dressings</p> <p><input type="checkbox"/> Elevated</p> <p><input type="checkbox"/> Ice <input type="text"/> Liters</p> <p>IV <input type="text"/></p> <p>Other <input type="text"/></p>	<p>Last Tet</p> <p><input type="radio"/> Less Than 5 Years</p> <p><input type="radio"/> 5 - 10 Years</p> <p><input type="radio"/> 10 Years +</p> <p><input type="radio"/> Unknown</p> <p><input checked="" type="radio"/> Unselected</p> <p><input type="checkbox"/> Up To Date</p> <p><input type="checkbox"/> Not Up To Date</p>	<p><input type="checkbox"/> Recently Seen For This Problem</p> <p><input type="checkbox"/> Diabetic</p>	<p>Visual Acuity</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Left Eye</td> <td style="width: 33%;">Right Eye</td> <td style="width: 33%;">Both Eyes</td> </tr> <tr> <td>Near <input type="text"/></td> <td>Near <input type="text"/></td> <td>Near <input type="text"/></td> </tr> <tr> <td>Far <input type="text"/></td> <td>Far <input type="text"/></td> <td>Far <input type="text"/></td> </tr> </table>	Left Eye	Right Eye	Both Eyes	Near <input type="text"/>	Near <input type="text"/>	Near <input type="text"/>	Far <input type="text"/>	Far <input type="text"/>	Far <input type="text"/>
Left Eye	Right Eye	Both Eyes										
Near <input type="text"/>	Near <input type="text"/>	Near <input type="text"/>										
Far <input type="text"/>	Far <input type="text"/>	Far <input type="text"/>										
<p>Patient Physician <input type="button" value="None"/> <input type="button" value="Physician List"/></p> <p><input type="text" value="Ruben Tenorio"/></p>												

Figure Chapter 3: -29: Triage/Medical Screening - History/Assessment

(Image: triage-med-screen-history-assess.bmp)

8. Click on check boxes and form fields to complete as appropriate.

Entering/Modifying Triage Information (continued)

Determination

- Click the History/Asses. button to continue entering patient information.

Triage/Medical Screening - Determination Active User James Ross, Jr., MD

Patient Name Byrd, Fickle
Adm # G16534459 Pat # 16548 SS # Bed Unknown

Priority <input type="radio"/> Emergent <input checked="" type="radio"/> Urgent <input type="radio"/> Non-Urgent <input type="radio"/> Fast Track <input type="radio"/> Minor Treatment Area <input type="radio"/> Not Selected	<input type="checkbox"/> Trauma <input type="checkbox"/> Non Trauma	Police/Animal Control Y N <input type="checkbox"/> Police At Scene <input type="checkbox"/> Police Came to ED Case Number <input type="text"/> Jurisdiction <input type="text"/> <input type="checkbox"/> Animal Control Notified	Assign ED Physician <input type="text"/> <input type="checkbox"/> E.D. Physician To Be Seen
<input checked="" type="checkbox"/> Translator Used <input type="checkbox"/> DNR <input type="checkbox"/> Patient Was Referred to ED	<input type="checkbox"/> Family Present <input type="checkbox"/> Family Not Present	Coma Scale <input type="text"/> Revised Trauma Score <input type="text"/>	Intro Purpose History/Asses Instructions Triage Summary Print Triage Record Exit No-Save Clear User Exit
Treatment At Triage <input type="checkbox"/> C-Collar <input type="checkbox"/> Sling <input type="checkbox"/> Backboard <input type="checkbox"/> Splint <input type="checkbox"/> Elevated <input type="checkbox"/> Dressings <input type="checkbox"/> Ice <input type="checkbox"/> O2 <input type="text"/> Liters IV: <input type="text"/> Other: <input type="text"/>	Guide <input type="checkbox"/> Not Referred <input type="checkbox"/> Referred To Other Services <input type="checkbox"/> Patient/Representative Agree <input type="checkbox"/> Patient/Representative Disagree <input type="checkbox"/> Teaching Performed <input type="checkbox"/> Referral List Provided		

Figure Chapter 3: -30: Triage/Medical Screening - Determination

(Image: triage-med-screen-determination.bmp)

Exit

- Click on check boxes and form fields to complete as appropriate.
- Click the Exit button to save updated patient information.

Printing and Viewing Triage Summary

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Triage

3. Click on the Triage button in the INPUT section.
[brings you to Triage (screen) 1]

Triage Summary

4a. Click on Triage Summary button to view.

or

Print Triage Record

4b. Click on Print Triage Record button to print.

Case 45

Medical Screening Record Summary				Active User: James Ross, Jr., MD
Patient Name	Byrd, Fickle			
Adm #	G16534459	Pat #	16548	SS #
				Bed: Unknown
Past Surgical History The informant denies any previous surgery.				
Review of Systems G5+ P5+ Ab4				
Social History Religion: Eastern Orthodox				
Nursing Triage Assessment Assessment recorded by The patient arrived for triage at 01/13/1997 11:08. The patient is assessed in triage as urgent. She is a 19 year old hispanic female. Onset of the problem occurred on 05/20/1997. Awake alert attentive. The bleeding was controlled. Skin W/D, pink nail, 2 second refill.				
Print	Apply Signature	Remove Signature	Clear User	Exit

Figure Chapter 3: -31: Triage Summary

(Image: triage-summary.bmp)

Tips and Hints: Triage:**In History/Assessment, ...**

- if the patient is a female of childbearing age, you need to enter the **Last Menstrual Period** in the LMP field (Example: 10/20/96 or 10/20/1996).
- click once on the box (Pregnant), in center of screen, if the patient is pregnant. TeleMed will automatically calculate the EDC and weeks of gestation. You should also enter the patient's history below for Gravida, Para, and Abortions.
- Please note if a *patient* is entered as a male you will not be able to enter an LMP.
- you can type in the physician's name or look it up in your phone directory by clicking once on **Physician List**. By typing the first 2 to 3 letters of the physician's name, the list will scroll down to the names with the same first letters. Highlight the correct physician by clicking on it once.

In Intro, ...

- Clicking on the "A" button will change the time and date to the current time and date. The patient's time of arrival defaults to the time the patient was entered (New Visit) in the computer.

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TeleMed Basic Patient Clinical Information (Doctors and Nurses)

Chief Complaints

Entering/Modifying Chief Complaint and Additional Complaints (std. menus)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Complaint

3. Click on the Complaint button in the INPUT section.

[brings you to the Complaint-Non-Pain screen]

Complaint - Non-Pain

Active User J.E. Ross, MD

Patient Name Garbo, Greta

Adm # 1895752

Pat # 7564552

SS # 450-81-9873

Bed 02

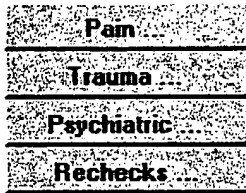
Complaint 1 of 1				Previous	Next	Add	Clear Complaint	Non-Pain
fall								Pain ...
								Trauma ...
Abdominal Distention	Edema/Generalized	Lethargy	Sickle Cell Crisis					Psychiatric ...
Abcess	Edema/Localized	Memory Loss	Skin Infection					Rechecks ...
Allergic Reaction	Fever (Adult)	Miscarriage	Stridor					
Altered Mental Status	Fever (Child)	Nasal Cong/Disc	Stroke					
Anxiety	Hematemesis	Nose Bleed	Syncope/Fainting					
Appetite Loss	Hematuria	Oral Lesion(s)	Tachycardia					
Asthma	Hemoptysis	Overdose	Thirst/Polydipsia					
Behavior Change	Hemorrhoids	Palpitations	Tinnitus					
Cardiac Arrest	Hypertension	Paresthesias	Unconsciousness					
CHF	Hypoglycemia	Poisoning	Urinary Retention					Complaint
Congestion/Nasal	Hypotension	Polypia	Vaginal Bleeding					Diff. Diagnosis
Constipation	Indigestion	Rash	Vaginal Discharge					Final Diagnosis
Cough	Influenza	Rectal Bleeding	Vertigo					
Decubitus Ulcers	Intoxication	Red Eye	Vision Disturbance					
Diarrhea	Itching	Respiratory Failure	Vomiting/Nausea					
Dizzy	Jaundice	Seizure	Weakness					Clear User
DKA/Hyperglycemia	Labor	Sexually Trans Disease	Weight Loss					
Dyspnea	Lesion/Growth	Shock	Wheezing					Exit

Figure Chapter 3: -32: Complaint - Non-Pain

(Image: complaint-non-pain.bmp)

Alternate access to this screen:

- Differential Diagnosis and Final Diagnosis

Entering/Modifying Chief Complaint and Additional Complaints (std. menus) (cont.)

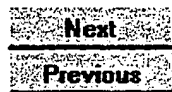
4. Go to (click) the appropriate Complaint category (if other than Non-Pain); IE. Pain, Trauma, Psychiatric or Rechecks.

5. Select complaints by clicking on the appropriate complaint buttons.



6. Use the Add button to enter any additional complaints (note the "Complaint 1 of 1" top left of screen maintains a count of complaints).

Note: A complaint can be manually entered (in form field) if it is not currently listed on any of the TeleMed complaint screens' buttons.



Note: Use the Next and Previous buttons to review currently entered Complaints.



Note: If you wish to remove a complaint you have entered, use the Clear Complaint button.



7. Click the Exit button to save updated patient information.

Entering/Modifying Chief Complaint and Additional Complaints (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

- 4a. Entering a new Chief Complaint entry:

To Add

- Click on To Add button.
- Open the pull down menu and select "Chief Complaint".

Editor - Add Mode Active User J.E. Ross, MD

Patient Name: Byrd, Newby Bed 01

Adm # K226534749 Pat # K226534749 SS #

Dictator: Ross MD Dictated: 02/12/97 10:50

Received: / / Add More

Patient Verification

Name: Byrd, Newby Text 1 of 1

Adm #: K226534749

Pat #: K226534749

Category

- Patient Identification and Statistics
- Patient Identification and Statistics
- Chief Complaint
- History of Present Illness
- Medications
- Allergies
- Past Medical History
- Previous Hospitalizations

Exit No-Save

Clear User

Exit

Figure Chapter 3: -33: Chief Complaint (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Chief Complaint and Additional Complaints (manual) (continued)

4b. Modify an existing Chief Complaint entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Chief Complaint.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS#: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: // Dictated: 02/12/97 12:50
 Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -34: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Current Chief Complaint(s)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Information**Summary****Medical Record Summary**

Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta

Adm #: 1895752

Pat #: 7564552

SS #: 450-81-9873

Bed G5a

General Information

Home phone: (210)377-3366. Work phone: (800)496-7547. The informant is the patient and EMS.

Chief Complaint

The patient's first complaint is fracture, left ankle.

The patient's second complaint is hematuria.

History of Present Illness

Onset of the problem occurred at approximately 12:10 on 09/18/97.

This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.

Allergies

Demerol, sulfa, Reglan

Medications

Current medications: None.

Past Medical History

Patient's physician: George Arrabire. Her last tetanus shot was between 5-10 years ago. Tetanus is not up to date. Past medical history includes: anemia, back injury and pneumonia.

Past Surgical History

Print

Apply Signature

Remove Signature

Clear User

Exit

Figure Chapter 3: -35: Medical Record Summary

(Image: medical-record-summary.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Chief Complaint:

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Chief Complaints text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- If the complaint you are looking for is not on any of the screens, you type it in the data field. Always try to choose a complaint from the screens. You can change the wording of the complaint or add to it after choosing it by clicking in the data field once and typing in the information you want.

History of Present Illness

Entering/Modifying History of Present Illness (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new History of Present Illness entry:

- Click on To Add button.
- Open the pull down menu and select "History of Present Illness".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby
 Adm # K226534749 Pat # K226534749 SS # Bed 01

Dictator: Ross MD
 Received: // Dictated: 02/12/97 10:50 Add More

Patient Verification
 Name: Byrd, Newby
 Adm #: K226534749
 Pat #: K226534749

Text 1 of 1

Category
Patient Identification and Statistics
Patient Identification and Statistics
Chief Complaint
History of Present Illness
Medications
Allergies
Past Medical History
Previous Hospitalizations

Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -36: History of Present Illness (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying History of Present Illness (manual) (continued)

4b. Modify an existing History of Present Illness entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate History of Present Illness.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta Text 2 of 2
 Adm #: 1895752
 Pat #: 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add
Prior
Next
First
Last
Delete
Edit Header
Exit No-Save
Clear User
Exit

Figure Chapter 3: -37: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing History of Present Illness

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Information

Summary

Medical Record Summary		Active User: James Ross, Jr., MD	
Patient Name: Garba, Greta	Adm # 1895752	Pat # 7564552	SS # 450-81-9873
		Bed G5a	
<p>General Information Home phone: (210)377-3366. Work phone: (800)496-7547. The informant is the patient and EMS.</p> <p>Chief Complaint The patient's first complaint is fracture, left ankle. The patient's second complaint is hematuria.</p> <p>History of Present Illness Onset of the problem occurred at approximately 12:10 on 09/18/97. This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.</p> <p>Allergies Demerol, sulfa, Reglan</p> <p>Medications Current medications: None.</p> <p>Past Medical History Patient's physician: George Arrabire. Her last tetanus shot was between 5-10 years ago. Tetanus is not up to date. Past medical history includes: anemia, back injury and pneumonia.</p> <p>Past Surgical History</p>			
Print		Apply Signature	Remove Signature
		Clear User	Exit

Figure Chapter 3: -38: Medical Record Summary

(Image: medical-record-summary.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: History of Present Illness:

- The Prephrased Text function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based History of Present Illness text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Prephrased Text for the Medical Record

Entering Prephrased Text in the Medical Record (local menus)

From the “Active Patient List” (your main tracking screen)

1. Select a patient from the “Grease Board” (list menu).

Medical Information

- 2. Click the Medical Information button.**

Prephrased Text

3. Click on the Prephrased Text button in the INPUT section.

Prephrased Transcript Text		Active User J.E.Ross, MD
Patient Name Garbo, Greta	Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02	
General Appearance	Neurological/Child	User Specific General Usage
Mental Status		Physicians must have a Federal ID number entered in TeleMed to use the Physician Specific function in this section.
Skin		
Head		
Eyes		
Ears		
Mouth		
Dental		
Throat		
Neck		
Chest		
Heart		
Lungs		
Abdomen		
Back		
Gonourinary		
Rectal		
Extremities		
Psych Admins		
Neurological/Infant		
		Exit-No-Save Clear User Exit

Figure Chapter 3: -39: Prephrased Transcript Text

(Image: `prephrased-transcript-text.bmp`)

```

User Specific
General Usage
Exit

```

4. Click the User Specific or General Usage buttons to view your user specific or ED wide Prephrased Text.
5. Select applicable Prephrased Text from the check box menu.
6. Click the Exit button to return to the Medical Information screen.

Modifying/Deleting Prephrased text in the Medical Record

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

Next
Prior

4. Click on Next / Prior (or First / Last) buttons to locate Medical Record category where Prephrased Text is placed.
5. Click on the multiline form field to manually add, delete or modify any text.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: **Greta Garbo**

Adm #: **1895752** Pat #: **7564552** SS #: **450-81-9873** Bed: **02**

Dictator: **Ross MD** Text 2 of 2

Received: **//** Dictated: **02/12/97 12:50**

Patient Verification:

Name: **Garbo, Greta**

Adm #: **1895752**

Pat #: **7564552**

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -40: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Tips and Hints: Prephrased Text:

- **The Prephrased Text function** (accessed from the Medical Information screen) provides check box menus (User Specific and General Usage) for entering a variety of locally customizable Medical Record categories:
 - Patient Identification and Statistics
 - Chief Complaint
 - History of Present Illness
 - Medications
 - Allergies
 - Past Medical History
 - Previous Hospitalizations
 - Past Surgical History
 - Review of Systems
 - Social History
 - Family History
 - Physical Exam
 - Labs
 - Tests
 - X-Rays
 - Therapeutics & Procedures
 - ED Course
 - Chart Review
 - Differential Diagnosis
 - Results of Therapy and Complications
 - Interval Exams
 - Consultations
 - Diagnosis
 - Referrals
 - Counseling
 - Prescriptions
 - Work/School Limitations/Excuse
 - Discharge
 - Neuro Assessment
 - Nurse Assessment
 - Nurse Notes
 - General
- TeleMed will automatically place your Prephrased Text entries under the appropriate Medical Record category (as you or your department defined when the entry was programmed into TeleMed).
- Use the **Medical Record Summary** to review / verify your modifications.
“Grease Board” → Medical Information (button) → Summary (button)
- Creating and modifying Prephrased Text entries (User Specific and General Usage) requires System Manager privileges. See System Manager’s Guide for instructions.

Past Medical/Surgical History

Entering/Modifying Past Medical/Surgical History (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Past Medical History

3. Click on the Past Medical History button in the INPUT section.
4. Click on check boxes and form fields to complete as appropriate.

Past Medical History Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

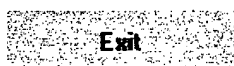
Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

<input checked="" type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input checked="" type="checkbox"/> Back Injury <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blindness <input type="checkbox"/> Cancer <input type="text"/> <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colitis <input type="checkbox"/> Congenital Heart Dis. <input type="checkbox"/> Deafness <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis	<input type="checkbox"/> Ear, Nose, Throat Dis. <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Emphysema <input type="checkbox"/> Eye Disease <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Gallstones <input type="checkbox"/> Gout <input type="checkbox"/> Headaches <input type="checkbox"/> Head Injury <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV <input type="checkbox"/> Hives <input type="checkbox"/> Irregular Heart Beat	Past Hospitalizations <input type="checkbox"/> Kidney Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lupus <input type="checkbox"/> Measles, Mumps <input type="checkbox"/> Mental/Emotional Problems <input type="checkbox"/> Mental Illness <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Meningitis <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Panic Attacks/Anxiety <input type="checkbox"/> Physical Disability <input checked="" type="checkbox"/> Pneumonia <input type="checkbox"/> Seizures/Epilepsy	0 Past Hospitalizations Recorded <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="text"/> <input type="checkbox"/> None Other: <input type="text"/>
---	--	---	---

Past Surgical History <input checked="" type="checkbox"/> Aneurysm <input checked="" type="checkbox"/> Appendectomy <input type="checkbox"/> Back <input type="checkbox"/> Brain <input type="checkbox"/> Breast <input type="checkbox"/> Broken Bones <input type="checkbox"/> Carotid <input type="checkbox"/> Cataracts <input type="checkbox"/> Coronary Bypass	<input type="checkbox"/> Cosmetic <input checked="" type="checkbox"/> C-Section <input type="checkbox"/> Dental <input type="checkbox"/> Exploratory <input type="checkbox"/> Eye <input type="checkbox"/> Gallbladder <input type="checkbox"/> Heart <input type="checkbox"/> Heart Catheter <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Hip <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Knee <input type="checkbox"/> Lung <input type="checkbox"/> Otolary <input type="checkbox"/> Peripheral Vascular <input type="checkbox"/> Retinal Laser <input type="checkbox"/> Sinus <input type="checkbox"/> Spinal	<input type="checkbox"/> Thyroid <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Transplant Corneal <input type="checkbox"/> Transplant Heart <input type="checkbox"/> Transplant Kidney <input type="checkbox"/> Transplant Liver <input type="checkbox"/> Transplant Lung <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Request Past Medical Charts <input type="checkbox"/> Charts Have Been Requested	<input type="checkbox"/> None Other: <input type="text"/>
---	---	---	--

Figure Chapter 3: -41: Past Medical/Surgical History

(Image: past-med-history.bmp)



6. Click the Exit button to save updated patient information.

Entering/Modifying Past Medical/Surgical History (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Past Medical/Surgical History entry:

- Click on To Add button.
- Open the pull down menu and select "Past Medical History".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby

Adm #: K226534749 Pat #: K226534749 SS # Bed 01

Dictator: Ross MD
 Received: // Dictated: 02/12/97 10:50 Add More

Patient Verification
 Name: Byrd, Newby
 Adm #: K226534749
 Pat #: K226534749

Text 1 of 1

Category

- Patient Identification and Statistics
- Patient Identification and Statistics
- Chief Complaint
- History of Present Illness
- Medications
- Allergies
- Past Medical History
- Previous Hospitalizations

Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -42: Past Medical History (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Past Medical/Surgical History (manual) (continued)

4b. Modify an existing Past Medical/Surgical History entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Past Medical/Surgical History.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add
 Prior
 Next
 First
 Last
 Delete
 Edit Header

 Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -43: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Past Medical/Surgical History

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Information

Summary

Medical Record Summary			Active User: James Ross, Jr., MD
Patient Name: Garbo, Greta	Adm #: 1895752	Pat #: 7564552	SS #: 450-81-9873
			Bed: G5a
<p>General Information Home phone: (210)377-3366. Work phone: (800)496-7547. The informant is the patient and EMS.</p> <p>Chief Complaint The patient's first complaint is fracture, left ankle. The patient's second complaint is hematuria.</p> <p>History of Present Illness Onset of the problem occurred at approximately 12:10 on 09/18/97. This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.</p> <p>Allergies Demerol, sulfa, Reglan</p> <p>Medications Current medications: None.</p> <p>Past Medical History Patient's physician: George Arrabire. Her last tetanus shot was between 5-10 years ago. Tetanus is not up to date. Past medical history includes: anemia, back injury and pneumonia.</p> <p>Past Surgical History</p>			
<p>Print Apply Signature Remove Signature Clear User Exit</p>			

Figure Chapter 3: -44: Medical Record Summary

(Image: medical-record-summary-a.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Past Medical/Surgical History:

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Past Medical/Surgical History text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Past Hospital Admissions

Entering/Modifying Past Hospital Admissions (via std. menu)

*From the "Active Patient List" (your main tracking screen) **

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Past Medical History

3. Click on the Past Medical History button in the INPUT section.

Past Hospitalizations

4. Click on the Past Hospitalizations button.

5. Complete the form fields as appropriate. (note instructions on screen)

Previous Hospitalizations Active User: James Ross, Jr. MD

Patient Name: Alvarez, Byrd
 Adm # 186592179 Pat # 186505019 SS # Bed 03

Hospitalization 1 of 0 Previous Next Add

To add a previous hospitalization, click "add", update the information fields, and click "exit" or "add".

When:

Where:

Brief Reason for Hospitalization

Clear User
Exit

Figure Chapter 3: -45: Previous Hospitalizations

(Image: previous-hospitalizations.bmp)



6. Click the Exit button to save updated patient information.

Entering/Modifying Past Hospital Admissions (manual)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add4a) Entering a new Past Hospital Admissions entry:

- Click on To Add button.
- Open the pull down menu and select "Previous Hospitalizations".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby

Adm #: K226534749 Pat #: K226534749 SS # Bed 01

Dictator: Ross MD
 Received: / /
 Dictated: 02/12/97 10:50
 Patient Verification: Name: Byrd, Newby
 Adm #: K226534749
 Pat #: K226534749

Text 1 of 1

Category

- Patient Identification and Statistics
- Patient Identification and Statistics
- Chief Complaint
- History of Present Illness
- Medications
- Allergies
- Past Medical History
- Previous Hospitalizations

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -46: Previous Hospitalizations (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Past Hospital Admissions (manual) (continued)

4b. Modify an existing Past Hospital Admissions entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to Previous Hospital Admissions.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta Text 2 of 2
 Adm #: 1895752
 Pat #: 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add
 Prior
 Next
 First
 Last
 Delete
 Edit Header

 Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -47: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Past Hospital Admissions

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Information

Summary

Medical Record Summary		Active User: James Ross, Jr., MD	
Patient Name: Garbo, Greta	Adm # 1895752	Pat # 7564552	SS # 450-81-9873
		Bed: G5a	
<p>General Information Home phone: (210)377-3366. Work phone: (800)496-7547. The informant is the patient and EMS.</p> <p>Chief Complaint The patient's first complaint is fracture, left ankle. The patient's second complaint is hematuria.</p> <p>History of Present Illness Onset of the problem occurred at approximately 12:10 on 09/18/97. This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.</p> <p>Allergies Demerol, sulfa, Reglan</p> <p>Medications Current medications: None.</p> <p>Past Medical History Patient's physician: George Arrabire. Her last tetanus shot was between 5-10 years ago. Tetanus is not up to date. Past medical history includes: anemia, back injury and pneumonia.</p> <p>Past Surgical History</p>			
Print		Apply Signature	Remove Signature
		Clear User	Exit

Figure Chapter 3: -48: Medical Record Summary

(Image: medical-record-summary-a.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Past Hospital Admissions:

- The Prephrased Text function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Past Hospital Admissions text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Review of Systems

Entering/Modifying Review of Systems (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Review of Systems

3. Click on the Review of Systems button in the INPUT section.

4. Complete the Initial 1 & 2 screens (general menu of systems) as appropriate.

5. Select any of the systems listed under "Complete System Review" if more detail is required.

Review of Systems Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Initial (Part 1)		Initial 1	Initial 2	Complete System Review	<input type="checkbox"/> Non-Contributory
HEAD Headache <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Syncope <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Recent Head Trauma <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ears Deafness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tinnitus <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Eyes Visual Complaint <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Photophobia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Inflammation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Discharge <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Nose Rhinitis <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Sinusitis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Mouth and Throat Sore Throat <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dysphagia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Bleeding Gums <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Neck Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Stiffness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		LUNGS Cough <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Sputum Production <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Hemoptysis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Pleuritic Chest Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Shortness of Breath <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No HEART Chest Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Palpitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Orthopnea <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dyspnea when Sleeping <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dyspnea on Exertion <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No MUSCULOSKELETAL Pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Stiffness to Extremities or Joints <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No SKIN Rash <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Lumps <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Easy Bruising <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Pregnant <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNABLE TO RESPOND	<input checked="" type="checkbox"/> Constitutional <input type="checkbox"/> Skin <input type="checkbox"/> Lymphatic <input checked="" type="checkbox"/> Bones Joints Muscles <input checked="" type="checkbox"/> Hematologic <input checked="" type="checkbox"/> Endocrine <input checked="" type="checkbox"/> Allergic & Immu. Hist. <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Breasts <input checked="" type="checkbox"/> Respiratory <input checked="" type="checkbox"/> Cardiovascular <input checked="" type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genitourinary <input checked="" type="checkbox"/> Neuro <input type="checkbox"/> Psychiatric		

Figure Chapter 3: -49: Review of Systems

(Image: review-of-systems.bmp)



6. Click the Exit button to save updated patient information.

Entering/Modifying Review of Systems (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Review of Systems entry:

- Click on To Add button.
- Open the pull down menu and select "Review of Systems".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/13/97 15:14

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 3 of 3

Category

- Previous Hospitalizations
- Previous Hospitalizations
- Past Surgical History
- Review of Systems
- Social History
- Family History
- Physical Exam
- Labs

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -50: Review of Systems (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Review of Systems (manual) (continued)

4b. Modify an existing Review of Systems entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons Review of Systems.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta Text 2 of 2
 Adm #: 1895752
 Pat #: 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -51: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

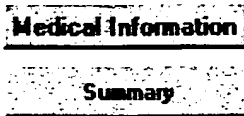
Exit

6. Click the Exit button to save updated patient information.

Viewing Review of Systems

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

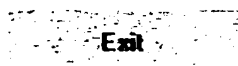


Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name	Garbo, Greta			
Adm #	1895752	Pat #	7564552	SS # 450-81-9873
				Bed G5a
<p>General Information Home phone: (210)377-3366. Work phone: (800)496-7547. The informant is the patient and EMS.</p> <p>Chief Complaint The patient's first complaint is fracture, left ankle. The patient's second complaint is hematuria.</p> <p>History of Present Illness Onset of the problem occurred at approximately 12:10 on 09/18/97. This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.</p> <p>Allergies Demerol, sulfa, Reglan</p> <p>Medications Current medications: None.</p> <p>Past Medical History Patient's physician: George Arrabire. Her last tetanus shot was between 5-10 years ago. Tetanus is not up to date. Past medical history includes: anemia, back injury and pneumonia.</p> <p>Past Surgical History</p>				
<p>Print Apply Signature Remove Signature Clear User Exit</p>				

Figure Chapter 3: -52: Medical Record Summary

(Image: medical-record-summary-2.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.



Tips and Hints: Review of Systems:

- The Prephrased Text function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Review of Systems text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Family History

Entering/Modifying Family History (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Family History

3. Click on the Family History button in the INPUT section.

4. Click on check boxes and form fields to complete as appropriate.

Family History Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

History of Blood Relative With:

- ☐ Asthma
- ☒ Cancer
- ☒ Diabetes
- ☐ Gallstones
- ☒ Heart Disease
- ☒ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine
- ☐ Peptic Ulcer Disease
- ☐ Seizures
- ☒ Stroke
- ☐ Tuberculosis

☐ Non-Contributory

If any element of Family History is checked
Non-Contributory will become unchecked

Exit No-Save
Clear User
Exit

Figure Chapter 3: -53: Family History

(Image: family-history.bmp)



5. Click the Exit button to save updated patient information.

Entering/Modifying Family History (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Family History entry:

- Click on To Add button.
- Open the pull down menu and select "Family History".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD
 Received: / /
 Dictated: 02/13/97 15:14

Patient Verification
 Name: Garbo, Greta
 Adm # 1895752
 Pat # 7564552

Text 3 of 3

Category

- Previous Hospitalizations
- Previous Hospitalizations
- Past Surgical History
- Review of Systems
- Social History
- Family History
- Physical Exam
- Labs

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -54: Family History (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Family History (manual) (continued)

4b. Modify an existing Family History entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Family History.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -55: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Family History

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary

Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta

Adm #: 1895752

Pat #: 7564552

SS #: 450-81-9873

Bed: G5a

Review of Systems

Mrs. Garbo is complaining of coughing and sputum production. The patient complains of a loss of appetite. The skin has no rash. There has been no bruising. HEAD: (+) for headaches, no previous head trauma and no history of syncope. EYES: no vision problems and no photophobia. EARS: no deafness or hearing loss, no previous tinnitus and no previous ear pain. NOSE: (+) rhinitis and no sinusitis. MOUTH: no mouth ulcers. THROAT: no sore throat and no previous dysphagia. PULMONARY: no pleuritic pain, no shortness of breath, no dyspnea while sleeping, (+) for cough, (+) for sputum production and no hemoptysis. CARDIAC: no palpitations and no orthopnea. GASTROINTESTINAL: (+) for loss of appetite, weight gain, nausea after eating, vomiting, frequent belching with acid reflux, diarrhea, occasional flatulence and constipation. The patient denies nausea, abdominal pain, hematemesis and bloody stools. GENITOURINARY: She is pregnant. (+) for orange or red urine, recent onset of polyuria, recent onset of nocturia, dysuria, urgency, increased frequency of urination, hematuria with no clots and vaginal discharge. The patient denies incontinence, dyspareunia, testicular pain, urethral discharge and hesitancy. Onset of menses was at age 11. Periods occur regularly approximately every 30 days and usually last for 4 days with medium flow. The date of the last normal period was 07/03/96. The next to last period occurred four weeks prior to the last period. There have been two pregnancies, one birth and one spontaneous abortion. Complications of pregnancy included: a C-section. PSYCHOLOGIC: Mrs. Garbo is a homosexual female with normal sexual adjustment. The patient indicated a recent relationship failure. She has had chronic debilitating illnesses. Mrs. Garbo suffers from hallucinations. The patient has had chronic insomnia.

Social History

Religion: Catholic. She is a cigarette smoker using 1/2 PPD. Alcohol use includes wine weekly. Mrs. Garbo denies use of drugs. The patient is married. She lives with a spouse and children.

Family History

There is a family history of blood relatives with cancer, diabetes, heart disease, high blood pressure and stroke.

Physical Exam

She is a 38 year old caucasian pregnant female. The calculated EDC is 04/09/97 based on the patient's stated LMP. The

Print

Apply Signature

Remove Signature

Clear User

Exit

Figure Chapter 3: -56: Medical Record Summary

(Image: medical-record-summary-2.bmp)

4. Click the Scroll Bar to view additional information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Family History:

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Family History text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Social History

Entering/Modifying Social History (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Family History

3. Click on the Social History button in the INPUT section.

4. Click on check boxes and form fields to complete as appropriate.

Social History Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed # 02

Sex <input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> Unselected	Marital <input type="radio"/> Single <input checked="" type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widow(er) <input type="radio"/> Separated <input type="radio"/> Unselected	Lives <input type="radio"/> Spouse <input checked="" type="radio"/> Spouse & Children <input type="radio"/> Adult Children <input type="radio"/> Minor Children <input type="radio"/> Parents <input type="radio"/> Adult Roommate <input type="radio"/> Significant Other <input type="radio"/> Alone <input type="radio"/> Nursing Home <input type="radio"/> Boarding Home <input type="radio"/> Unselected	Smoker? <input checked="" type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Non-Smoker	Smoke Amount <input type="radio"/> < 1/4 PPD <input type="radio"/> 1/2 PPD <input type="radio"/> 1 PPD <input type="radio"/> 2 PPD <input type="radio"/> > 2 PPD <input type="radio"/> Unselected
Race: Caucasian	If Smoker, Alcohol or Drug elements are other than Unselected or None, Non-Contributory will become checked			<input type="checkbox"/> Non-Contributory
Alcohol <input type="checkbox"/> Beer <input checked="" type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/> None	Alcohol Frequency <input type="radio"/> < 1/Month <input checked="" type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> Daily <input type="radio"/> All Day <input type="radio"/> Unselected	Drugs <input type="checkbox"/> Amphetamines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Cocaine <input type="checkbox"/> LSD <input type="checkbox"/> Marijuana	<input type="checkbox"/> Narcotics <input type="checkbox"/> PCP <input type="checkbox"/> Other <input checked="" type="checkbox"/> None	<input type="button" value="Admission"/> <input type="button" value="Guarantor"/> <input type="button" value="Insurance"/> <input type="button" value="Employer/Contact"/> <input type="button" value="Discharge"/> <input type="button" value="Exit No-Save"/> <input type="button" value="Clear User"/> <input type="button" value="Exit"/>
Double Click on Religion To Select Adventist African Meth. Episcopal Agnostic All Nations Anglican				Religion: Catholic

Figure Chapter 3: -57: Social History

(Image: social-history.bmp)

Exit

5. Click the Exit button to save updated patient information.

Entering/Modifying Social History (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Social History entry:

- Click on To Add button.
- Open the pull down menu and select "Social History".

Editor - Add Mode Active User J.E. Ross, MD

Patient Name Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator Ross MD

Received // Dictated 02/13/97 15:14 Add More

Patient Verification

Name Garbo, Greta Text 3 of 3

Adm # 1895752

Pat # 7564552

Category

- Previous Hospitalizations
- Previous Hospitalizations
- Past Surgical History
- Review of Systems
- Social History
- Family History
- Physical Exam
- Labs

Exit No-Save

Clear User

Exit

Figure Chapter 3: -58: Social History (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Social History (manual) (continued)

4b. Modify an existing Social History entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Social History.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add
 Prior
 Next
 First
 Last
 Delete
 Edit Header

 Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -59: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

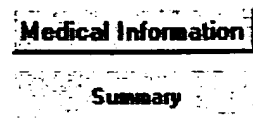
Exit

6. Click the Exit button to save updated patient information.

Viewing Social History

From the "Active Patient List" (your main tracking screen)

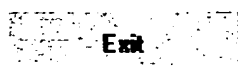
1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]



Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name: Garbo, Greta	Adm # 1895752	Pat # 7564552	SS # 450-81-9873	Bed G5a
<h3>Review of Systems</h3> <p>Mrs. Garbo is complaining of coughing and sputum production. The patient complains of a loss of appetite. The skin has no rash. There has been no bruising. HEAD: (+) for headaches, no previous head trauma and no history of syncope. EYES: no vision problems and no photophobia. EARS: no deafness or hearing loss, no previous tinnitus and no previous ear pain. NOSE: (+) rhinitis and no sinusitis. MOUTH: no mouth ulcers. THROAT: no sore throat and no previous dysphagia. PULMONARY: no pleuritic pain, no shortness of breath, no dyspnea while sleeping, (+) for cough, (+) for sputum production and no hemoptysis. CARDIAC: no palpitations and no orthopnea. GASTROINTESTINAL: (+) for loss of appetite, weight gain, nausea after eating, vomiting, frequent belching with acid reflux, diarrhea, occasional flatulence and constipation. The patient denies nausea, abdominal pain, hematemesis and bloody stools. GENITOURINARY: She is pregnant. (+) for orange or red urine, recent onset of polyuria, recent onset of nocturia, dysuria, urgency, increased frequency of urination, hematuria with no clots and vaginal discharge. The patient denies incontinence, dyspareunia, testicular pain, urethral discharge and hesitancy. Onset of menses was at age 11. Periods occur regularly approximately every 30 days and usually last for 4 days with medium flow. The date of the last normal period was 07/03/96. The next to last period occurred four weeks prior to the last period. There have been two pregnancies, one birth and one spontaneous abortion. Complications of pregnancy included: a C-section. PSYCHOLOGIC: Mrs. Garbo is a homosexual female with normal sexual adjustment. The patient indicated a recent relationship failure. She has had chronic debilitating illnesses. Mrs. Garbo suffers from hallucinations. The patient has had chronic insomnia.</p> <h3>Social History</h3> <p>Religion: Catholic. She is a cigarette smoker using 1/2 PPD. Alcohol use includes wine weekly. Mrs. Garbo denies use of drugs. The patient is married. She lives with a spouse and children.</p> <h3>Family History</h3> <p>There is a family history of blood relatives with cancer, diabetes, heart disease, high blood pressure and stroke.</p> <h3>Physical Exam</h3> <p>She is a 38 year old caucasian pregnant female. The calculated EDC is 04/09/97 based on the patient's stated LMP. The</p>				
<div> <div>Print</div> <div>Apply Signature</div> <div>Remove Signature</div> <div>Clear User</div> <div>Exit</div> </div>				

Figure Chapter 3: -60: Medical Record Summary

(Image: medical-record-summary-2.bmp)



4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Social History:

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Social History text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Patient Allergies

Entering/Modifying Patient Allergies (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Allergies

3. Click on the Allergies button in the INPUT section.

4. Complete the screen as appropriate. If no allergies, click None button.

Allergies Active User: J.E.Ross, MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Demerol

ACE Inhibitors	Cephalosporins	Novocain	None
Adhesive Tape	Codeine	Penicillin	
Alcohol	Codapazine	Phenothiazines	
Antihistamines	Decongestants	Quinolones	
Antiinflammatories	Demerol	Reglan	
Aspirin	Dyazide	Steroids	
Barbiturates	Erythromycin	Sulla	
Benzodiazepines	HCTZ	Tetracycline	
Beta Blockers	Iodine	Tetanus	
Betadine	Lanoxin	Theophyllin	
Bronchodilators	Lidocaine	Thorazine	
Calcium Channel Blockers	Morphine	Toradol	
	Muscle Relaxers	Valproic Acid	Exit No-Save
	Nitrates	X-Ray Dye	Clear User
		Xylocaine	Exit

Figure Chapter 3: -61: Allergies

(Image: allergies.bmp)

Exit

5. Click the Exit button to save updated patient information.

Entering/Modifying Patient Allergies (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Allergies entry:

- Click on To Add button.
- Open the pull down menu and select "Allergies".

Editor - Add Mode Active User J.E. Ross, MD

Patient Name: Byrd, Newby Bed 01

Adm # K226534749 Pat # K226534749 SS #

Dictator: Ross MD Add More

Received: / / Dictated: 02/12/97 10:50

Patient Verification: Text 1 of 1

Name: Byrd, Newby

Adm #: K226534749

Pat #: K226534749

Category

- Patient Identification and Statistics**
- Patient Identification and Statistics
- Chief Complaint
- History of Present Illness
- Medications
- Allergies
- Past Medical History
- Previous Hospitalizations

Exit No-Save

Clear User

Exit

Figure Chapter 3: -62: Allergies (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Allergies (manual) (continued)

4b. Modify an existing Allergies entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to Allergies.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode		Active User: J.E. Ross, MD												
Patient Name: Greta Garbo														
Adm #: 1895752	Pat #: 7564552	SS #: 450-81-9873	Bed: 02											
Dictator: Ross MD														
Received: / /	Dictated: 02/12/97 12:50													
Patient Verification		Text 2 of 2												
Name: Garbo, Greta														
Adm #: 1895752														
Pat #: 7564552		Use buttons to select category -->												
Manually/Custom entered text will appear here														
<table border="1"> <tr><td>To Add</td></tr> <tr><td>Prior</td></tr> <tr><td>Next</td></tr> <tr><td>First</td></tr> <tr><td>Last</td></tr> <tr><td>Delete</td></tr> <tr><td>Edit Header</td></tr> <tr><td> </td></tr> <tr><td>Exit No-Save</td></tr> <tr><td>Clear User</td></tr> <tr><td>Exit</td></tr> </table>				To Add	Prior	Next	First	Last	Delete	Edit Header		Exit No-Save	Clear User	Exit
To Add														
Prior														
Next														
First														
Last														
Delete														
Edit Header														
Exit No-Save														
Clear User														
Exit														

Figure Chapter 3: -63: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

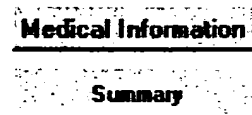
Exit

6. Click the Exit button to save updated patient information.

Viewing Patient Allergies

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

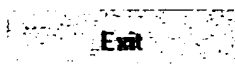


Medical Record Summary		Active User James Ross, Jr., MD	
Patient Name	Garbo, Greta	Adm #	1895752
Pat #	7564552	SS #	450-81-9873
		Bed	G5a
<p>General Information Home phone: (210)377-3366. Work phone: (800)496-7547. The informant is the patient and EMS.</p> <p>Chief Complaint The patient's first complaint is fracture, left ankle. The patient's second complaint is hematuria.</p> <p>History of Present Illness Onset of the problem occurred at approximately 12:10 on 09/18/97. This patient was walking across the street when she fell and hurt her left wrist and right knee. She also bumped her lower abdomen on the curb. She subsequently noted blood in the toilet when she urinated and is not on her period. She missed the last one and thinks she's probably pregnant again because she's urinating frequently and has had some morning sickness. She denies any head or neck trauma and does not feel faint. No cold sweats or shortness of breath.</p> <p>Allergies Demerol, sulfa, Reglan</p> <p>Medications Current medications: None.</p> <p>Past Medical History Patient's physician: George Arrabire. Her last tetanus shot was between 5-10 years ago. Tetanus is not up to date. Past medical history includes: anemia, back injury and pneumonia.</p> <p>Past Surgical History:</p>			
Print		Apply Signature	Remove Signature
		Clear User	Exit

Figure Chapter 3: -64: Medical Record Summary

(Image: medical-record-summary.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.



Tips and Hints: Allergies:

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Allergies text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Physical Examination

Entering/Modifying Physical Examination (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Physical Examination entry:

- Click on To Add button.
- Open the pull down menu and select "Physical Exam".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: // Dictated: 02/13/97 15:14 Add More

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 3 of 3

Category

- Previous Hospitalizations
- Previous Hospitalizations
- Past Surgical History
- Review of Systems
- Social History
- Family History
- Physical Exam
- Labs

Exit No-Save
Clear User
Exit

Figure Chapter 3: -65: Physical Exam (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Physical Examination (manual) (continued)

4b. Modify an existing Physical Examination entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Physical Exam.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode		Active User J.E. Ross, MD											
Patient Name Greta Garbo													
Adm # 1895752	Pat # 7564552	SS # 450-81-9873	Bed 02										
Dictator: Ross, MD		Received: / /											
Patient Verification		Dictated: 02/12/97 12:50											
Name: Garbo, Greta		Text 2 of 2											
Adm # 1895752		Use buttons to select category -->											
Pat # 7564552		Manually/Custom entered text will appear here											
		<table border="1"> <tr><td>To Add</td></tr> <tr><td>Prior</td></tr> <tr><td>Next</td></tr> <tr><td>First</td></tr> <tr><td>Last</td></tr> <tr><td>Delete</td></tr> <tr><td>Edit Header</td></tr> <tr><td>Exit No-Save</td></tr> <tr><td>Clear User</td></tr> <tr><td>Exit</td></tr> </table>		To Add	Prior	Next	First	Last	Delete	Edit Header	Exit No-Save	Clear User	Exit
To Add													
Prior													
Next													
First													
Last													
Delete													
Edit Header													
Exit No-Save													
Clear User													
Exit													

Figure Chapter 3: -66: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

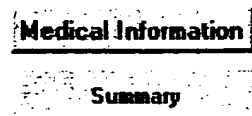
Exit

6. Click the Exit button to save updated patient information.

Viewing Physical Examination

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]



Medical Record Summary			Active User: James Ross, Jr., MD
Patient Name: Garbo, Greta			
Adm #: 1895752	Pat #: 7564552	SS #: 450-81-9873	Bed: G5n
<p>Review of Systems</p> <p>Mrs. Garbo is complaining of coughing and sputum production. The patient complains of a loss of appetite. The skin has no rash. There has been no bruising. HEAD: (+) for headaches, no previous head trauma and no history of syncope. EYES: no vision problems and no photophobia. EARS: no deafness or hearing loss, no previous tinnitus and no previous ear pain. NOSE: (+) rhinitis and no sinusitis. MOUTH: no mouth ulcers. THROAT: no sore throat and no previous dysphagia. PULMONARY: no pleuritic pain, no shortness of breath, no dyspnea while sleeping, (+) for cough, (+) for sputum production and no hemoptysis. CARDIAC: no palpitations and no orthopnea. GASTROINTESTINAL: (+) for loss of appetite, weight gain, nausea after eating, vomiting, frequent belching with acid reflux, diarrhea, occasional flatulence and constipation. The patient denies nausea, abdominal pain, hematemesis and bloody stools. GENITOURINARY: She is pregnant. (+) for orange or red urine, recent onset of polyuria, recent onset of nocturia, dysuria, urgency, increased frequency of urination, hematuria with no clots and vaginal discharge. The patient denies incontinence, dyspareunia, testicular pain, urethral discharge and hesitancy. Onset of menses was at age 11. Periods occur regularly approximately every 30 days and usually last for 4 days with medium flow. The date of the last normal period was 07/03/96. The next to last period occurred four weeks prior to the last period. There have been two pregnancies, one birth and one spontaneous abortion. Complications of pregnancy included: a C-section. PSYCHOLOGIC: Mrs. Garbo is a homosexual female with normal sexual adjustment. The patient indicated a recent relationship failure. She has had chronic debilitating illnesses. Mrs. Garbo suffers from hallucinations. The patient has had chronic insomnia.</p> <p>Social History</p> <p>Religion: Catholic. She is a cigarette smoker using 1/2 PPD. Alcohol use includes wine weekly. Mrs. Garbo denies use of drugs. The patient is married. She lives with a spouse and children.</p> <p>Family History</p> <p>There is a family history of blood relatives with cancer, diabetes, heart disease, high blood pressure and stroke.</p> <p>Physical Exam</p> <p>She is a 38 year old caucasian pregnant female. The calculated EDC is 04/09/97 based on the patient's stated LMP. The</p>			
<div style="display: flex; justify-content: space-between; margin: 0;"> Print Apply Signature Remove Signature Clear User Exit </div>			

Figure Chapter 3: -67: Medical Record Summary

(Image: medical-record-summary-2.bmp)



4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Physical Examination

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Physical Exam text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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TeleMed Patient Dictation, Diagnosis and Clinical Management (Doctors and Nurses)

Differential Diagnosis

Entering/Modifying Differential Diagnosis (std. menu)

*From the "Active Patient List" (your main tracking screen)**

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Differential Diagnosis

3. Click on the Differential Diagnosis button in the INPUT section.

4. Add and Delete differential diagnosis as required (follow on-screen instructions).

Differential Diagnosis Active User: J.E. Ross, MD

Patient Name: Byrd, Newby

Adm #: K226534749 Pat #: K226534749 SS # Bed: 01

Complaint: 1 of 1 Previous Next fever

Select Differential Diagnosis Associated With This Complaint
(maximum of 80 may be selected for each complaint)

retropharyngeal abscess

rheumatic fever

rheumatoid arthritis

ricketsial infection

ricketsial pox

Rocky Mountain spotted fever

salmonellosis

sarcoidosis

scarlet fever

scrub typhus

sepsis (uncertain etiology)

shunt infection

sinusitis (bacterial, acute)

splenic abscess (acute)

subphrenic abscess (acute)

To add differential diagnosis to selected list select diagnosis from top list by clicking the selection one time then click "Add". Selection will appear in bottom list.

To delete a selected differential diagnosis select diagnosis from bottom list, click the selection one time and click "Delete".

Selected Differential Diagnosis List

Add > influenza

Delete malignancy (unspecified type)

Clear pharyngitis (bacterial/acute)

pneumonia (bacterial/acute)

pyelonephritis (acute)

sinusitis (bacterial, acute)

tonsillitis (acute)

uncertain etiology

Complaint

Dif. Diagnosis

Final Diagnosis

Clear User

Exit

Figure Chapter 3: -68: Differential Diagnosis

(Image: differential-diagnosis.bmp)

Exit

5. Click the Exit button to save updated patient information.

Entering/Modifying Differential Diagnosis (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Differential Diagnosis entry:

- Click on To Add button.
- Open the pull down menu and select "Differential Diagnosis".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby

Adm #: K226534749 Pat #: K226534749 SS # Bed: 01

Dictator: Ross MD

Received: / /

Dictated: 02/14/97 11:06

Patient Verification

Name: Byrd, Newby

Adm #: K226534749

Pat #: K226534749

Text 1 of 1

Category:

- Chief Complaint
- Procedures & Therapeutics
- ED Course
- Chart Review
- Differential Diagnosis
- Results of Therapy & Complications
- Interval Exams
- Consultations

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -69: Differential Diagnosis (in Editor Add Mode)

(Image: editor-add-mode-3.bmp)

Entering/Modifying Differential Diagnosis (manual) (continued)

4b. Modify an existing Differential Diagnosis entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Differential Diagnosis.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD

Received: // Dictated: 02/12/97 12:50

Patient Verification

Name: Garbo, Greta Text 2 of 2

Adm # 1895752

Pat # 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -70: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Differential Diagnosis

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name: Garbo, Greta	Adm #: 1895752	Pat #: 7564552	SS #: 450-81-9873	Bed: G5a
<p>Emergency Department Course</p> <p><i>Differential Diagnosis</i> The differential diagnosis for the first complaint, fracture, left ankle, includes: appendicitis (acute); coagulopathy; cystitis (acute); diverticulitis (acute); glomerulonephritis (acute); systemic lupus erythematosus; uncertain etiology; and ureteral calculus.</p> <p><i>Interval Exams</i> In addition to the initial evaluation, the doctor was in to reevaluate the patient or discuss treatment with the patient at the following times: 13:49 13:49 15:48</p> <p><i>Consultations</i> Bebe T Newbirth specializing in OB-GYN was called on 09/08/96 at 11:57 and was consulted on 09/08/96 at 12:28. Called office. Called exchange. The case was discussed, consultant concurs with the decision to discharge patient. Consultant wishes to see the patient at her office in 2 days to recheck.</p> <p><i>Diagnosis</i> 1: spiral simple fracture of the left midshaft first metatarsal, posteriorly displaced, with 15° angulation.</p> <p><i>Referrals</i> The patient was referred to: Bebe T Newbirth, OB-GYN Richard Adam, Podiatry</p>				
Print		Apply Signature	Remove Signature	Clear User
Exit				

Figure Chapter 3: -71: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Differential Diagnosis

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Differential Diagnosis text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- ***Alternate access to this screen:***
Complaint and Final Diagnosis

Multiple & Final Diagnoses

Entering/Modifying Multiple Diagnoses (std. menu)

*From the "Active Patient List" (your main tracking screen) **

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Diagnosis

3. Click on the Differential Diagnosis button in the INPUT section.

- 4a. If the Complaint section has been completed to a diagnosable level of detail, the Diagnosis screen will display differential diagnosis.

Diagnosis Active User: J.E. Ross, MD

Patient Name: Byrd, Newby
Adm #: K226534749 Pat #: K226534749 SS # Bed 01

Complaint 1 of 1 Previous Next Add fever

Double Click on Item to Select a Diagnosis from the Differential Diagnosis List

- Rocky Mountain spotted fever
- acute pyrexia
- bronchitis (bacterial/acute)
- cellulitis (acute)
- collagen vascular disease (unspecified type)
- diverticulitis (acute)
- drug induced fever
- gastroenteritis (viral)
- influenza
- malignancy (unspecified type)
- pharyngitis (bacterial/acute)
- pneumonia (bacterial/acute)
- pyelonephritis (acute)
- tonsillitis (acute)
- uncertain etiology
- upper respiratory infection (viral)

Clear Diagnosis Select Diagnosis

Diagnosis

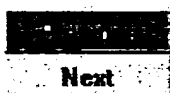
Rocky Mountain spotted fever

Diagnosis Categories:

- Acid-Base/Fluid/Elec.
- Endocrine/Metabolic
- GI & Hepatic
- GU
- Hematologic
- Musculoskeletal
- Neurologic
- Cardiac
- Pulmonary
- Non-Compliance
- Complaint
- Diff. Diagnosis
- Final Diagnosis
- Clear User
- Exit

Figure Chapter 3: -72: Diagnosis (with differential diagnosis)

(Image: diagnosis.bmp)



- Select each Complaint (Previous & Next buttons) and enter diagnosis.
- Additional diagnosis groups are provided at the right of screen.

Entering/Modifying Multiple Diagnoses (std. menu) (continued)

- 4b. If the Complaint section has been partially completed (i.e. not to a diagnosable level of detail) or no differential diagnosis exists for the complaint, the Diagnosis screen will display the appropriate diagnosis screen (Pain, Non-Pain, Trauma, etc)

Diagnosis - Trauma - Injury Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Complaint 1 of 1 Previous Next Add fall

Select trauma type

Abrasion	Deformity	Injury/Twisting	Needle Stick	Copy Complaint
Amputation	Dislocation	Insect Bite	Penetrating Trauma	
Animal Bite	Dog Bite	Insect Sting	Perforation	
Ant Bites	Electrical Burn	Laceration	Puncture Wound	
Assault	Electrocution	Lac/in Lake or River	Radiation	Clear Diagnosis
Avulsion	Explosion	Lac/in Ocean	Sexual Assault	
Barotrauma (Altitude)	Fall	Multiple Trauma	Shark Attack	
Barotrauma (Scuba)	Foreign Body	MVA	Snake Bite	
Bicycle	Fracture	MVA/Head On	Spider Bite	Clear User
Blunt Trauma	Gunshot Wound	MVA/Side On	Sprain	
Burn	GSW/High Velocity	MVA/Rear End	Strain	
Cat Bite	Hematoma/Bruise	MVA/Rollover	Stab Wound	
Chemical Burn	Hemorrhage	MVA/Bus	Sunburn	Exit
Choking	Human Bite	MVA/Pedestrian		
Clenched Fist Lac	Hyperthermia	MVA/Motorcycle		
Cold Injury/Frostbite	Hypothermia	MVA/Single Vehcl		
Contusion	Injury	MVA/2 Vehicle		
Crush Injury	Injury/Pulling/Lift	MVA/Multi Vehcl		

fall

Figure Chapter 3: -73: Diagnosis (for trauma-injury)

(Image: diagnosis-trauma-injury.bmp)

- Select the appropriate diagnosis for each complaint (more than 1 of 1)

Entering/Modifying Multiple Diagnoses (std. menu) (continued)

- 4c. If no Complaint(s) have been entered, the Diagnosis screen will display a blank field diagnosis screen.

Diagnosis Active User: J.E. Ross, MD

Patient Name: Kid, Young
 Adm #: C77483299 Pat #: C77483299 SS #: Bed: 07A

Complaint 1 of 1 Previous Next Add

Double Click on Item to Select a Diagnosis from the Differential Diagnosis List

Diagnosis

- Acid-Base/Fluid/Elec.
- Endocrine/Metabolic
- GI & Hepatic
- GU
- Hematologic
- Musculoskeletal
- Neurologic
- Cardiac
- Pulmonary
- Non-Compliance
- Complaint
- Dif. Diagnosis
- Final Diagnosis

Clear Diagnosis Select Diagnosis

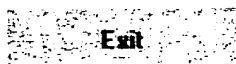
Diagnosis

Clear User Exit

Figure Chapter 3: -74: Diagnosis (no complaint information entered)

(Image: diagnosis-nc.bmp)

- Click on the appropriate Diagnosis button at right of screen to enter menu based diagnosis.



5. Click the Exit button to save updated patient information.

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Entering/Modifying Final/Multiple Diagnosis (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new (Final/Multiple) Diagnosis entry:

- Click on To Add button.
- Open the pull down menu and select "Diagnosis".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby Dictated: 02/14/97 11:47

Adm # K226534749 SS # Bed: 01

Dictator: Ross MD Text 1 of 1

Received: / / Add More

Patient Verification

Name: Byrd, Newby

Adm #: K226534749

Pat #: K226534749

Category

- Patient Identification and Statistics
- Differential Diagnosis
- Results of Therapy & Complications
- Interval Exams
- Consultations
- Diagnosis
- Referrals
- Counseling

Exit No-Save

Clear User

Exit

Figure Chapter 3: -75: (Final/Multiple) Diagnosis (in Editor Add Mode)

(Image: editor-add-mode-4.bmp)

Entering/Modifying Final/Multiple Diagnosis (manual) (continued)**4b. Modify an existing (Final/Multiple) Diagnosis entry:**

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Diagnosis.
- Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add
Prior
Next
First
Last
Delete
Edit Header
Exit No-Save
Clear User
Exit

Figure Chapter 3: -76: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

5. Click the Exit button to save updated patient information.

Viewing Diagnosis

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: J.E. Ross, MD	
Patient Name: Alvarez, Byrd					
Adm #	186592179	Pat #	186505019	SS #	Bed Unknown

hypertension; hyperthyroidism; hyperventilation syndrome; menopause; migraine; mitral valve prolapse; panic disorder; phenylpropanolamine; pulmonary embolism; syncope; uncertain etiology; vascular collapse (shock); and vertigo.

Consultations
Ariel Hernandez specializing in Family Practice was consulted on 09/08/96 at 16:44. Called office. Called exchange. Called beeper. Consultant concurs with the decision to admit patient and has given orders.

Diagnosis
1: panic disorder.

Prescriptions
Prescriptions given to the patient include:
Darvocet-N 100, quantity 14, 1 tab po q 3-4* as needed, for 2 days.

J.E. Ross, MD signature applied.

Nursing

Vitals							Recorded By Kelly Townsend, RN
Date	Time	Pulse	Resp	BP	Temp	O2Sat	
11/22/96	11:51	86	23	120/95	101.3 (T)	BCla	

Nurse Assessment
The patient is assessed in triage as non-urgent.
Assessment recorded by Kelly Townsend, RN
There was no treatment prior to arrival. Mrs. Alvarez was ambulatory on arrival.

The patient is awake, alert, attentive, moving all extremities well. No fever at home. No nausea, vomiting or diarrhea. No loss of consciousness.

Nurse Notes
11/22/96 11:51 Nurse note recorded by Kelly Townsend, RN

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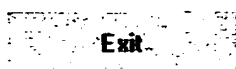
Apply Sig.
Remove Sig.

Clear User
Exit

Figure Chapter 3: -77: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Final Diagnoses

Entering/Modifying Final Diagnoses (std. menu)

*From the "Active Patient List" (your main tracking screen) **

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Complaint

- 3a. Click on the Complaint button in the INPUT section.

Or

Differential Diagnosis

- 3b. Click on the Differential Diagnosis button in the INPUT section.

Final Diagnosis

4. Click on the Final Diagnosis button.

5. Add and Clear Diagnosis as required. The diagnosis screen options & format will be the same as described on page 126, "Entering/Modifying Multiple Diagnoses (std. menu)".

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Multiple & Final Diagnosis

- The Prephrased Text function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based (Final/Multiple) Diagnosis text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- *Alternate access to this screen:*
Complaint and Differential Diagnosis

Lab Requests & Results

Requesting Labs (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Lab Requests

3. Click on the Lab Requests button in the INPUT section.

- This opens the "Labs Ordered - General" screen. For more specific labs, click on the appropriate buttons under "Other Labs" on the right side of the screen.

4. Request each lab needed via the lab screen's check box menu. Complete any editable form fields as required.

Labs Ordered - General Active User J.E.Ross, MD

Patient Name Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

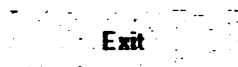
Show Labs Ordered Requested by J.E.Ross, MD

General	Chemistry	Infectious Disease	Blood Bank	Other Labs
<input type="checkbox"/> CBC	<input type="checkbox"/> NA	<input type="checkbox"/> Rapid Strep Screen	<input type="checkbox"/> Type and Screen	<input type="checkbox"/> Blood Bank
<input type="checkbox"/> Urinalysis	<input type="checkbox"/> K	<input type="checkbox"/> Monospot (Heterophile)	<input type="checkbox"/> Type and Cross	<input type="checkbox"/> Chemistry
<input type="checkbox"/> Blood Sugar	<input type="checkbox"/> CL	<input type="checkbox"/> RPR	<input type="checkbox"/> Units	<input type="checkbox"/> Cultures/Micro
<input type="checkbox"/> ABG's	<input type="checkbox"/> CO2	<input type="checkbox"/> Serum HIV	<input type="checkbox"/> Whole Blood	<input type="checkbox"/> Drug Scrns/Lev
<input type="checkbox"/> Co-oximetry	<input type="checkbox"/> BUN	<input type="checkbox"/> Chlamydia Prep	<input type="checkbox"/> Crossmatched	<input type="checkbox"/> General
<input type="checkbox"/> Electrolytes	<input type="checkbox"/> Creatinine	<input type="checkbox"/> Cervical GC Prep	<input type="checkbox"/> Uncrossmatched	<input type="checkbox"/> Hematology
<input type="checkbox"/> SMA 7	<input type="checkbox"/> Blood Sugar	<input type="checkbox"/> HBsAg	<input type="checkbox"/> Type Specific	<input type="checkbox"/> Infect Disease
<input type="checkbox"/> SMA 13	<input type="checkbox"/> Alkaline Phosphatase	<input type="checkbox"/> Drug Screens/Levels	<input type="checkbox"/> Uncrossmatched	<input type="checkbox"/> Lumbar Punct
<input type="checkbox"/> SMA 15	<input type="checkbox"/> SGOT (AST)	<input type="checkbox"/> Urine Drug Screen	<input type="checkbox"/> Universal Donor	<input type="checkbox"/> Spec Chem
<input type="checkbox"/> SMA 20	<input type="checkbox"/> LDH	<input type="checkbox"/> Serum Drug Screen	<input type="checkbox"/> Packed Red Blood Cells (PRBCs)	<input type="checkbox"/> Urine Chem
<input type="checkbox"/> ER Panel	<input type="checkbox"/> CPK	<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Lumbar Puncture	
<input type="checkbox"/> Cardiac Enzymes	<input type="checkbox"/> Rapid CPK MB	<input type="checkbox"/> Aspirin	<input type="checkbox"/> #1: C and S	
<input type="checkbox"/> Cardiac Isoenzymes	<input type="checkbox"/> Amylase, Serum	<input type="checkbox"/> Theophyllin	<input type="checkbox"/> #1: Gram Stain	
<input type="checkbox"/> Liver Panel	<input type="checkbox"/> Bilirubin, Total	<input type="checkbox"/> Digoxin Level	<input type="checkbox"/> #1: CIEOs	
<input type="checkbox"/> Hepatitis Panel	<input type="checkbox"/> Ca	<input type="checkbox"/> Alcohol, Serum	<input type="checkbox"/> #2: Protein	
<input type="checkbox"/> Thyroid Panel	<input type="checkbox"/> Mg	<input type="checkbox"/> Dilantin	<input type="checkbox"/> #2: Glucose	
<input type="checkbox"/> Serum Pregnancy	<input type="checkbox"/> Total Protein	<input type="checkbox"/> Cultures/Micro	<input type="checkbox"/> #3: Cell Count	
<input type="checkbox"/> Urine Pregnancy	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Throat C and S	<input type="checkbox"/> #3: Differential	
<input type="checkbox"/> Hematology	<input type="checkbox"/> Iron, Serum	<input type="checkbox"/> Urine C and S	<input type="checkbox"/> Minutes Apart	
<input type="checkbox"/> CBC	<input type="checkbox"/> Ammonia, Serum	<input type="checkbox"/> Blood C and S	<input type="checkbox"/> 1 Time 1 Site	
<input type="checkbox"/> Sed Rate		<input type="checkbox"/> 2 Times 2 Sites		
<input type="checkbox"/> PT		<input type="checkbox"/> Sputum C and S		
<input type="checkbox"/> PTT				

Exit No-Save Clear User Exit

Figure Chapter 3: -78: Labs Ordered- General

(Image: labs-ordered.bmp)



5. Click the Exit button to return to the Medical Information screen.

Viewing Labs Requested

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Lab Requests

3. Click on the Lab Requests button in the INPUT section.

Show Labs Ordered

4. Click on the Show Labs Ordered button.

Lab Order History Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Labs
 09/08/96 10:55 labs requested by Jimmie McBride, RN
 Labs requested include: CBC, serum pregnancy (HCG), urinalysis, urine C&S and ER panel.

Page 1 of 1
 Last

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Next

Clear User

Exit

Figure Chapter 3: -79: Lab Order History

(Image: lab-order-history.bmp)

Exit

5. Click the Exit button to return to the Medical Information screen.

Entering/Updating Lab Results (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Lab Results

3. Click on the Lab Results button in the HISTORICAL section.

Lab Results Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

<p>Blood Gasses</p> <p>Chemistry</p> <p>Drug Screen</p> <p>Hematology</p> <p>Levels</p> <p>Lumbar Puncture</p> <p>Micro</p> <p>Micro Gram Stains</p> <p>Special Chemistry</p> <p>Urinalysis</p> <p>Urine Micro</p>	<p>Lab Results by Time Entered</p> <div style="border: 1px solid black; padding: 5px;"> <p>09/08/96 11:12:02</p> <p>09/08/96 11:14:04</p> <p>09/08/96 11:48:03</p> <p>09/08/96 20:50:08</p> </div> <p>Lab History</p> <p>To enter new results, click "Blank For New Results," select desired subscreen (Ex. Micro) and enter lab results. Exit subscreen and repeat until all desired subscreen information has been entered. Exit back to this screen and click "Save Changes."</p> <p>To change a lab result, click on Lab Result by Time selection, select desired subscreen and change appropriate entry. Exit back to this screen and click "Save Changes."</p> <p style="text-align: center;"> <input type="button" value="Blank For New Results"/> <input type="button" value="Save Changes"/> <input type="button" value="Clear User"/> <input type="button" value="Exit"/> </p>
---	--

Figure Chapter 3: -80: Lab Results (menu)

(Image: lab-results.bmp)

- 4a. To enter new results

Blank For New Results

- Click the "Blank for New Results" button.
- Select desired lab category (Ex. Blood Gasses, next page).
- Enter results.

Entering/Updating Lab Results (std. menu) (continued)4b. To update results:

- Select desired lab category (Ex. Blood Gases).
- Click on check boxes and form fields to complete as appropriate.

Blood Gases		Active User: J.E. Ross, MD	
Patient Name: Garbo, Greta			
Adm # 1895752	Pet # 7564552	SS # 450-81-9873	Bed 02

PH	7.22	(7.340-7.450)	
PCO2	28	(35-45)	
PO2	102	(75-90)	
O2SAT	99	± (94-97)	
HCO3	15	(24-31)	
BX	-9		
FI02	100	± (21-100)	

Cooximeter	
Carboxyhemoglobin	±
Methemoglobin	±
Oxyhemoglobin	±

Assessment	
<input type="checkbox"/>	Normal
<input checked="" type="checkbox"/>	Metabolic Acidosis
<input type="checkbox"/>	Metabolic Alkalosis
<input type="checkbox"/>	Respiratory Acidosis
<input type="checkbox"/>	Respiratory Alkalosis
<input type="checkbox"/>	Mild Hypoxia
<input type="checkbox"/>	Moderate Hypoxia
<input type="checkbox"/>	Severe Hypoxia
<input type="checkbox"/>	Metabolic Acidosis w/Respiratory Compensation
<input type="checkbox"/>	Respiratory Acidosis w/Metabolic Compensation

Figure Chapter 3: -81: Blood Gases

(Image: blood-gases.bmp)



5. Click the Exit button to save Lab Results.

Entering/Updating Lab Comments in the Medical Record (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Labs comment entry:

- Click on To Add button.
- Open the pull down menu and select "Labs".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD Dictated: 02/13/97 15:14 Add More

Received: // Text 3 of 3

Patient Verification

Name: Garbo, Greta

Adm #: 1895752

Pat #: 7564552

Category

- Previous Hospitalizations
- Past Surgical History
- Review of Systems
- Social History
- Family History
- Physical Exam
- Labs

Exit No-Save

Clear User

Exit

Figure Chapter 3: -82: Labs (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Lab Comments (manual) (continued)

4b. Modify an existing Lab comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Labs.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD Received: / / Dictated: 02/12/97 12:50

Patient Verification Name: Garbo, Greta Text 2 of 2

Adm # 1895752 Pat # 7564552 Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -83: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Lab Results

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Lab Results

3. Click on the Lab Results button in the HISTORICAL section.

Lab Results Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta
 Ada #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 07A

<p>Blood Gasses</p> <p>Chemistry</p> <p>Drug Screen</p> <p>Hematology</p> <p>Levels</p> <p>Lumbar Puncture</p> <p>Micro</p> <p>Micro Gram Stains</p> <p>Special Chemistry</p> <p>Urmalysis</p> <p>Urine Micro</p>	<p>Lab Results by Time Entered</p> <div style="border: 1px solid black; padding: 5px;"> <p>09/08/96 11:12:02</p> <p>09/08/96 11:14:04</p> <p>09/08/96 11:48:03</p> <p>09/08/96 20:50:08</p> </div> <p style="text-align: right;">Lab History</p> <p><small>To enter new results, click "Blank For New Results," select desired subscreen (i.e. Micro) and enter lab results. Exit subscreen and repeat until all desired subscreen information has been entered. Exit back to this screen and click "Save Changes."</small></p> <p><small>To change a lab result click on Lab Result by Time selection, select desired subscreen and change appropriate entry. Exit back to this screen and click "Save Changes."</small></p> <p style="text-align: right;"> <input type="button" value="Blank For New Results"/> <input type="button" value="Save Changes"/> <input type="button" value="Clear User"/> <input type="button" value="Exit"/> </p>
--	--

Figure Chapter 3: -84: Lab Results (menu)

(Image: lab-results.bmp)

Lab History

4. Click the Lab History button to see all results up to the latest.
 - If you wish to examine an older set of results, double-click the appropriate date/time entry and then click the Overview button.

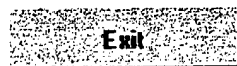
Viewing Lab Results

→ Option A (continued)

Lab History		Active User: James Ross, Jr., MD																														
Patient Name: Garbo, Greta	Adm # 1895752	Pat # 7564552																														
	SS # 450-81-9873	Bed G5a																														
Labs Labs requested include: CBC, serum pregnancy (HCG), urinalysis, urine C&S and ER panel. Lab results of 11:12:02: Chemistry <table> <tr><td>NA</td><td>139 Meq/L (136-149)</td></tr> <tr><td>K</td><td>3.2 Meq/L (3.5-5.0)</td></tr> <tr><td>CL</td><td>102 Meq/L (99-110)</td></tr> <tr><td>CO2</td><td>26 Meq/L (24-31)</td></tr> <tr><td>BUN</td><td>12 Mg/L (10-26)</td></tr> <tr><td>Creatinine</td><td>0.8 Mg/L (0.6-1.5)</td></tr> <tr><td>Glucose</td><td>118 Mg/L (70-110)</td></tr> </table> Lab results of 11:14:04: Chemistry <table> <tr><td>Alk Phos</td><td>103 MU/ML (Adult 30-100, Child 3-4 X Adult)</td></tr> <tr><td>SGOT</td><td>28 IU/L (0-40)</td></tr> <tr><td>SGPT</td><td>31 IU/L (0-40)</td></tr> <tr><td>LDH</td><td>153 IU/L (90-180)</td></tr> <tr><td>T Bili</td><td>1.0 Mg/DL (0.2-1.5)</td></tr> <tr><td>CA</td><td>10.1 Mg/DL (8.5-10.5)</td></tr> <tr><td>CA++</td><td>4.3 Mg/DL (4.0-4.8)</td></tr> <tr><td>Mg</td><td>2.1 Mg/DL (1.8-2.6)</td></tr> </table>			NA	139 Meq/L (136-149)	K	3.2 Meq/L (3.5-5.0)	CL	102 Meq/L (99-110)	CO2	26 Meq/L (24-31)	BUN	12 Mg/L (10-26)	Creatinine	0.8 Mg/L (0.6-1.5)	Glucose	118 Mg/L (70-110)	Alk Phos	103 MU/ML (Adult 30-100, Child 3-4 X Adult)	SGOT	28 IU/L (0-40)	SGPT	31 IU/L (0-40)	LDH	153 IU/L (90-180)	T Bili	1.0 Mg/DL (0.2-1.5)	CA	10.1 Mg/DL (8.5-10.5)	CA++	4.3 Mg/DL (4.0-4.8)	Mg	2.1 Mg/DL (1.8-2.6)
NA	139 Meq/L (136-149)																															
K	3.2 Meq/L (3.5-5.0)																															
CL	102 Meq/L (99-110)																															
CO2	26 Meq/L (24-31)																															
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Creatinine	0.8 Mg/L (0.6-1.5)																															
Glucose	118 Mg/L (70-110)																															
Alk Phos	103 MU/ML (Adult 30-100, Child 3-4 X Adult)																															
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LDH	153 IU/L (90-180)																															
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CA	10.1 Mg/DL (8.5-10.5)																															
CA++	4.3 Mg/DL (4.0-4.8)																															
Mg	2.1 Mg/DL (1.8-2.6)																															
Print	Apply Signature	Remove Signature																														
	Clear User	Exit																														

Figure Chapter 3: -85: Lab (results) Overview

(Image: lab-history.bmp)



- Click the Exit button (twice) to return to the Medical Information screen.

Viewing Lab Results (continued)

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary			Active User: James Ross, Jr., MD	
Patient Name: Garbo, Greta				
Adm #: 1895752	Pat #: 7564552	SS #: 450-81-9873	Bed: G5a	
Review of Systems <p>Mrs. Garbo is complaining of coughing and sputum production. The patient complains of a loss of appetite. The skin has no rash. There has been no bruising. HEAD: (+) for headaches, no previous head trauma and no history of syncope. EYES: no vision problems and no photophobia. EARS: no deafness or hearing loss, no previous tinnitus and no previous ear pain. NOSE: (+) rhinitis and no sinusitis. MOUTH: no mouth ulcers. THROAT: no sore throat and no previous dysphagia. PULMONARY: no pleuritic pain, no shortness of breath, no dyspnea while sleeping, (+) for cough, (+) for sputum production and no hemoptysis. CARDIAC: no palpitations and no orthopnea. GASTROINTESTINAL: (+) for loss of appetite, weight gain, nausea after eating, vomiting, frequent belching with acid reflux, diarrhea, occasional flatulence and constipation. The patient denies nausea, abdominal pain, hematemesis and bloody stools. GENITOURINARY: She is pregnant. (+) for orange or red urine, recent onset of polyuria, recent onset of nocturia, dysuria, urgency, increased frequency of urination, hematuria with no clots and vaginal discharge. The patient denies incontinence, dyspareunia, testicular pain, urethral discharge and hesitancy. Onset of menses was at age 11. Periods occur regularly approximately every 30 days and usually last for 4 days with medium flow. The date of the last normal period was 07/03/96. The next to last period occurred four weeks prior to the last period. There have been two pregnancies, one birth and one spontaneous abortion. Complications of pregnancy included: a C-section. PSYCHOLOGIC: Mrs. Garbo is a homosexual female with normal sexual adjustment. The patient indicated a recent relationship failure. She has had chronic debilitating illnesses. Mrs. Garbo suffers from hallucinations. The patient has had chronic insomnia.</p>				
Social History <p>Religion: Catholic. She is a cigarette smoker using 1/2 PPD. Alcohol use includes wine weekly. Mrs. Garbo denies use of drugs. The patient is married. She lives with a spouse and children.</p>				
Family History <p>There is a family history of blood relatives with cancer, diabetes, heart disease, high blood pressure and stroke.</p>				
Physical Exam <p>She is a 38 year old caucasian pregnant female. The calculated EDC is 04/09/97 based on the patient's stated LMP. The</p>				
Print	Apply Signature	Remove Signature	Clear User	Exit

Figure Chapter 3: -86: Medical Record Summary

(Image: medical-record-summary-b.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Lab Requests and Results

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Lab (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- ***Alternate access to this screen***
Tests & X-Rays screens

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X-Ray Requests

Requesting X-Rays (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Radiology Requests

3. Click on the Radiology Requests button in the INPUT section.

4. Select the appropriate X-Ray input screen: General (default), Extremities or Other.

5. Select the appropriate X-Ray location from the screen's check box menu.

Radiology - X-Rays - General Active User: J.E. Ross, MD

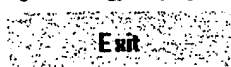
Patient Name: Byrd, Newby
 Adm #: K226534749 Pat #: K226534749 SS #: Bed: 01

Requested by: J.E. Ross, MD

<input type="checkbox"/> AC Joint w/Stress Left	<input type="checkbox"/> Coccyx	<input type="checkbox"/> Mandible	<input type="checkbox"/> Scapula Left	<input type="checkbox"/> Shield Abdomen
<input type="checkbox"/> AC Joint w/Stress Right	<input type="checkbox"/> Cystogram	<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> Scapula Right	<input type="checkbox"/> Portable
<input type="checkbox"/> AC Joint Left	<input type="checkbox"/> Cystourethrogram	<input type="checkbox"/> Navicular Views Left	<input type="checkbox"/> Shoulder Left	
<input type="checkbox"/> AC Joint Right	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Navicular Views Right	<input type="checkbox"/> Shoulder Right	
<input type="checkbox"/> Barium Enema	<input type="checkbox"/> Gastrografin Enema	<input type="checkbox"/> Neck Soft Tissue AP and Lat	<input type="checkbox"/> Sinus Films	
<input type="checkbox"/> Barium Swallow		<input type="checkbox"/> Neck Soft Tissue Lat	<input type="checkbox"/> Skull	
<input type="checkbox"/> C Spine (Standard)	<input type="checkbox"/> Hip Left	<input type="checkbox"/> Orbit Left	<input type="checkbox"/> Sternum	Order History
<input type="checkbox"/> C Spine Full	<input type="checkbox"/> Hip Right	<input type="checkbox"/> Orbit Right	<input type="checkbox"/> T Spine	General
<input type="checkbox"/> C Spine Flexion/Extension	<input type="checkbox"/> Humerus Left	<input type="checkbox"/> Pelvis AP	<input type="checkbox"/> TMJ's	Extremities
<input type="checkbox"/> Calcaneus Left	<input type="checkbox"/> Humerus Right	<input type="checkbox"/> Retrograde Pyelogram	<input type="checkbox"/> Testicular Scan	Other Radiol
<input type="checkbox"/> Calcaneus Right	<input type="checkbox"/> IVP	<input type="checkbox"/> Rib Detail Left	<input type="checkbox"/> Tibia/Fibula Left	Labs
<input type="checkbox"/> Chest PA and Lat (Standard)	<input type="checkbox"/> KUB	<input type="checkbox"/> Rib Detail Right	<input type="checkbox"/> Tibia/Fibula Right	Tests
<input type="checkbox"/> Chest - AP	<input type="checkbox"/> KUB/Upright Abd		<input type="checkbox"/> UGI Series	Exit No-Save
<input type="checkbox"/> Chest - PA	<input type="checkbox"/> L-S Spine		<input type="checkbox"/> Urethrogram	Clear User
<input type="checkbox"/> Clavicle Left			<input type="checkbox"/> VQ Lung Scan	Exit
<input type="checkbox"/> Clavicle Right			<input type="checkbox"/> Venogram Lower Ext. Left	
			<input type="checkbox"/> Venogram Lower Ext. Right	

Figure Chapter 3: -87: Radiology-X-Ray-General

(Image: radiology-xrays-general.bmp)



6. Click the Exit button to save updated patient information.

Updating X-Ray Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new X-Rays comment entry:

- Click on To Add button.
- Open the pull down menu and select "X-Rays".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD Received: // Dictated: 02/19/97 10:47

Patient Verification: Text 2 of 2

Name: Garbo, Greta

Adm #: 1895752

Pat #: 7564552

Category

- Patient Identification and Statistics**
- Labs
- Tests
- X-Rays
- Procedures & Therapeutics
- ED Course
- Chart Review
- Differential Diagnosis

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -88: X-Rays (in Editor Add Mode)

(Image: editor-add-mode-5.bmp)

Entering/Modifying X-Ray Comments (manual) (continued)

4b. Modify an existing X-Ray comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate X-Rays.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD Received: / / Dictated: 02/12/97 12:50

Patient Verification: Name: Garbo, Greta Text 2 of 2

Adm # 1895752 Pat # 7564552 Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -89: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing X-Ray Requests

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Radiology Requests

3. Click on the Radiology Requests button in the INPUT section.

Order History

4. Click on the Order History button.

Radiology Order History Active User James Ross, Jr., MD

Patient Name Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-01-9873 Bed G5a

X-Rays
 09/08/96 10:56 Radiology requested by Jimmie McBride, RN
 X-ray requests include: right knee with sunrise and left wrist.

Print Apply Signature Remove Signature Clear User Exit

Figure Chapter 3: -90: X-Ray Order History

(Image: rad-order-history.bmp)

Exit

5. Click the Exit button (twice) to return to the Medical Information screen.

Viewing X-Ray Requests (continued)**→ Option B***From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary			Active User: James Ross, Jr. MD
Patient Name: Byrd, Binkie	Adm #: F107576349	Pat #: F97588089	SS: B
			Bed: Unknown
<p>Tests</p> <p>08/13/97 10:38 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates no acute ischemic change.</p> <p>08/13/97 10:56 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates T wave inversion.</p> <p>09/08/97 10:50 EKG analyzed by James Ross, Jr., MD. The EKG demonstrates no acute ischemic change and T wave inversion.</p> <p>Procedures & Therapeutics</p> <p>Laceration repairs include: Laceration number 1 dermis layer (length 24 cm). To clean the laceration, Betadine solution was used. Irrigation was performed using a syringe and catheter and normal saline. Steri-strips were applied.</p> <p>Laceration number 1 subcutaneous tissue (length 4 cm). To clean the laceration, Betadine scrub was used. Irrigation was performed using a Zero-Wet splash shield and 10% Betadine in normal saline.</p> <p>06/11/97 16:45 D5W was administered as a 1000 cc bolus.</p> <p>09/10/97 14:15 A nasogastric tube was inserted using a Levin tube. Tube suction was set to low intermittent suction.</p> <p>09/10/97 14:25 A hard collar was placed on the patient to provide cervical restraint. Upper extremity immobilization was obtained using a rigid splint. The patient was placed in a reverse Trendelenburg position.</p> <p>09/15/97 14:01 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf countertraction, anterior pressure on the foot with posterior pressure on the distal tibia. The anterior ankle dislocation was reduced using knee flexion at 30°, foot traction, calf countertraction and anterior pressure on the distal tibia with posterior pressure on the foot.</p> <p>09/15/97 14:31 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf</p>			
Print	Apply Signature	Remove Signature	Clear User Exit

Figure Chapter 3: -91: Medical Record Summary

(Image: medical-record-summary-c.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: X-Ray Requests

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based X-Ray Requests (comments, not requests) text into the Medical Record. Go to page 78, “Prephrased Text for the Medical Record”, for more information on the use of Prephrased Text.
- ***Alternate access to this screen***
Tests screen

Test Requests

Requesting Tests (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Test Requests

3. Click on the Test Requests button in the INPUT section.

4. Select the appropriate Test from the screen's check box menu.

Tests Active User: J.E. Ross, MD

Patient Name: Byrd, Newby

Adm #: K226534749 Pat #: K226534749 SS #: Bed #: 01

Requested by: J.E. Ross, MD

☐ EKG
☐ Electroencephalogram
☐ Exercise Tolerance
☐ Fetal Monitoring
☐ Intracranial Pressure Monitor
☐ Peak Flow
☐ Pulmonary Function

Labs
 X-Ray
 Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -92: Tests

(Image: tests.bmp)

Exit

5. Click the Exit button to save updated patient information.

Updating Test Requests (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Tests comment entry:

- Click on To Add button.
- Open the pull down menu and select "Tests".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: / / Dictated: 02/19/97 10:47

Patient Verification
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Category

- Patient Identification and Statistics
- Labs
- Tests
- X-Rays
- Procedures & Therapeutics
- ED Course
- Chart Review
- Differential Diagnosis

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -93: Tests (in Editor Add Mode)

(Image: editor-add-mode-5.bmp)

Entering/Modifying Test Comments (manual) (continued)

Next
Prior

4b. Modify an existing Tests comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Tests.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode		Active User: J.E. Ross, MD	
Patient Name: Greta Garbo			
Adm #: 1895752	Pat #: 7564552	SS #: 450-81-9873	Bed: 02
Dictator: Ross MD			
Received: / /	Dictated: 02/12/97 12:50		
Patient Verification		Text 2 of 2	
Name: Garbo, Greta			
Adm #: 1895752			
Pat #: 7564552		Use buttons to select category -->	
Manually/Custom entered text will appear here			
		To Add Prior Next First Last Delete Edit Header	
		Exit No-Save	
		Clear User	
		Exit	

Figure Chapter 3: -94: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Test Requests

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name	Byrd, Binkie			
Adm #	F107576349	Pat #	F97588089	SS #
				Bed Unknown

Tests

08/13/97 10:38 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates no acute ischemic change.

08/13/97 10:56 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates T wave inversion.

09/08/97 10:50 EKG analyzed by James Ross, Jr., MD. The EKG demonstrates no acute ischemic change and T wave inversion.

Procedures & Therapeutics

Laceration repairs include: Laceration number 1 dermis layer (length 24 cm). To clean the laceration, Betadine solution was used. Irrigation was performed using a syringe and catheter and normal saline. Steri-strips were applied.

Laceration number 1 subcutaneous tissue (length 4 cm). To clean the laceration, Betadine scrub was used. Irrigation was performed using a Zero-Wet splash shield and 10% Betadine in normal saline.

06/11/97 16:45
D5W was administered as a 1000 cc bolus.

09/10/97 14:15
A nasogastric tube was inserted using a Levin tube. Tube suction was set to low intermittent suction.

09/10/97 14:25
A hard collar was placed on the patient to provide cervical restraint. Upper extremity immobilization was obtained using a rigid splint. The patient was placed in a reverse Trendelenburg position.

09/15/97 14:01
The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf countertraction, anterior pressure on the foot with posterior pressure on the distal tibia. The anterior ankle dislocation was reduced using knee flexion at 30°, foot traction, calf countertraction and anterior pressure on the distal tibia with posterior pressure on the foot.

09/15/97 14:31
The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf

Print	Apply Signature	Remove Signature	Clear User	Exit
-------	-----------------	------------------	------------	------

Figure Chapter 3: -95: Medical Record Summary

(Image: medical-record-summary-5.bmp)

4. Click the Scroll Bar to view additional information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Test Requests

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Test Requests (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- ***Alternate access to this screen***
X-Ray screen

Procedures & Therapeutics

Ordering/Documenting Therapeutic Procedures (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Therapeutics

3. Click on the Therapeutics button in the INPUT section.

4. Select the appropriate Procedure then click on check boxes and form fields to complete as appropriate. (ACLS/CPR example follows)

Therapeutic Procedures				Active User J.E.Ross, MD
ACLS	DNR	Lacerations	Splinting	
Abdominal Hernia	Death Certificate	Laryngeal Foreign Body	Tendonitis	
Ace	Dislocations	Local Anesthetic	Thoracentesis	
Airways	Dressings	Mast Trousers	Thoracotomy	
Allergic Reaction/Anaphylaxis	Endotracheal Tube	Nasogastric Tube	Transfusion	
Anesthetics	Ear Wax & Foreign Body	Nail Bed Laceration	Umbilical Artery Catheter	
Arthritis	Epistaxis	Nail Removal	Urethral Dilator	
Arthrocentesis	Esophageal Foreign Body	Nasal Foreign Body	Urology Treatment	
Blakemore Tube	Eye	Neuro Procedures	Vaginal Delivery	
Block	Family Counseling	Nosebleed	Ventilator	
Blood/Platelets	Fluid Resuscitation	O2		
Bucks Traction	Foley	Orogastric Tube	Common Nurse Orders	
Burns	Foreign Body	Ointments	Date 02/11/97	
Burr Holes	Gastric Lavage	Pacing	Time 13:41	
Bursitis	Gynecologic	Paracentesis		
CPR	Heimlich Maneuver	Pericardiocentesis	Diagnostic Procedures	
Carbon Monoxide Rx	Hematoma Evacuation	Peritoneal Dialysis	Medications/IV Solutions	
Cardiac Arrest	Hemorrhoids	Pneumothorax	Therapeutic Procedures	
Cardiac Pacing	Hernia	Positioning		
Cast Application	Incision & Drainage	Procedure Medications	Exit No-Save	
Catheter Removal	IV Fluids	Rectal Procedures	Clear User	
Central Line	IV Lines	Regional Anesthetic		
Cervical Traction	Immobilization	Respiratory Therapy		
Chest Tube	Ingrown Nail	Restraints		
Child Birth	Interosseous Infusion	Sedation/Analgesia		
Code Sheet	Intubation	Skin Graft		
Cricothyrotomy	Isolation	Slings/Straps		
Cutdowns	Joint Aspiration	Sit Lamp Exam		
			Exit	

Figure Chapter 3: -96: Therapeutic Procedures

(Image: therapeutic-procedures.bmp)

ACLS/CPR: Screen 1

ACLS/CPR 1 Active User: J.E. Ross, MD

Patient Name: **Byrd, Newby**

Adm # **K226534749** Pat # **K226534749** SS # Bed **01**

Requested by: **J.E. Ross, MD**

CPR <input type="checkbox"/> External Chest Compression <input type="checkbox"/> Simultaneous Compression-Ventilation <input type="checkbox"/> Interposed Abdominal Compression <input type="checkbox"/> CPR Discontinued Patient Pronounced <input type="checkbox"/> CPR Discontinued Viable Rhythm	IV Solution <input type="checkbox"/> NS <input type="checkbox"/> D50W <input type="checkbox"/> LR <input type="checkbox"/> D5W <input type="checkbox"/> mEq KCl <input type="checkbox"/> D5NS <input type="checkbox"/> D5LR Other <input type="text"/> <input type="checkbox"/> D5 1/2 NS	Given/Performed <input type="text"/> History of ACLS <input type="text"/>	Weight <input type="checkbox"/> Estimated <input type="text"/> lbs <input type="text"/> kg
Defibrillation/Cardioversion <input type="checkbox"/> Joules Non-Synchronized <input type="text"/> (200-400 Adult, 2-4 J/kg Child) <input type="checkbox"/> Joules Synchronized <input type="text"/> (25-400 Adult, 2 J/kg Child)	Intubation Endotracheal Tube <input type="checkbox"/> Premature 2.5 Non-cuffed <input type="checkbox"/> Newborn 3.0 Non-cuffed <input type="checkbox"/> Newborn 3.5 Non-cuffed <input type="checkbox"/> 6 Month 3.5 Non-cuffed <input type="checkbox"/> 8 Month 4.0 Non-cuffed <input type="checkbox"/> 1 Year 4.5 Non-cuffed <input type="checkbox"/> 2 Year 5.0 Non-cuffed <input type="checkbox"/> 4 Year 5.5 Non-cuffed	<input type="checkbox"/> 6 Year 6.0 Cuffed <input type="checkbox"/> 8 Year 6.5 Cuffed <input type="checkbox"/> 10 Year 7.0 Cuffed <input type="checkbox"/> 12 Year 7.5 Cuffed <input type="checkbox"/> 14 Year 7.5 Cuffed Female 7.5-8.5 Recommended Male 7.5-9.0 Recommended	After each medication or procedure is given/performed, press "Given/Performed" to record timing of events. To view sequence of events and times, press "History of ACLS"
Ventilation <input type="checkbox"/> Manual Ventilation w/Bag/Valve <input type="checkbox"/> Mechanical Ventilation FIO2 <input type="text"/> (21-100%) Tidal Volume <input type="text"/> (100-990 ml) Rate <input type="text"/> (10-16/min)	IV Access <input type="checkbox"/> Peripheral Line (Above Diaphragm) <input type="checkbox"/> External Jugular Line <input type="checkbox"/> Internal Jugular Line <input type="checkbox"/> Subclavian Line	Airway <input type="checkbox"/> Oral Inserted <input type="checkbox"/> Nasal Inserted	Meds 1 <input type="text"/> Meds 2 <input type="text"/> Rhythm <input type="text"/> Exit No-Save <input type="text"/> Clear User <input type="text"/> Exit <input type="text"/>

Figure Chapter 3: -97: ACLS/CPR - 1

(Image: acls-cpr-1.bmp)

5a. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on **Meds 1**, **Meds 2** and/or **Rhythm** buttons to access additional ACLS/CPR screens.



6. Click the **Exit** button to save updated patient information.

ACLS/CPR: Medications 1

ACLS/CPR - Medications 1 Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Requested by: J.E. Ross, MD

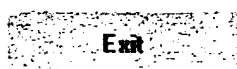
<input type="checkbox"/> Epinephrine <input type="text"/> mg (1 mg initial, up to 5 mg subsequent doses)	<input type="checkbox"/> Verapamil Initial Bolus <input type="text"/> mg (2.5-5.0 mg)	Given/Performed <input type="button" value="Given/Performed"/>	Weight <input type="checkbox"/> Estimated <input type="text"/> 129 lbs <input type="text"/> 59 kg
<input type="checkbox"/> Atropine <input type="text"/> mg (0.5-1.0 mg initial, total 2-3 mg or 0.03-0.04 mg/kg)	<input type="checkbox"/> Verapamil Repeat Bolus <input type="text"/> mg (5-10 mg, up to 30 mg total)		
Antiarrhythmics		Defibrillation/ Cardioversion	After each medication or procedure is given/performed, press "Given/Performed" to record timing of events. To view sequence of events and times, press "History of ACLS"
<input type="checkbox"/> Lidocaine Initial Bolus <input type="text"/> mg (1-1.5 mg/kg bolus)	<input type="checkbox"/> Diltiazem Initial Bolus <input type="text"/> mg (0.25 mg/kg)	<input type="checkbox"/> Joltes Synchronized	
<input type="checkbox"/> Lidocaine Repeat Bolus <input type="text"/> mg (0.5 mg/kg bolus 10 min after 1st)	<input type="checkbox"/> Diltiazem Repeat Bolus <input type="text"/> mg (0.35 mg/kg 15 min after initial)	<input type="checkbox"/> Joltes Synchronized	
<input type="checkbox"/> Lidocaine Infusion <input type="text"/> mg/min (2-4 mg/min after pulse resorted)	<input type="checkbox"/> Adenosine Initial 6 mg Rapid Bolus <input type="checkbox"/> Adenosine Repeat <input type="text"/> mg (12 mg)	<input type="checkbox"/> Joltes Synchronized	
<input type="checkbox"/> Lidocaine Endotracheal <input type="text"/> mg (2.5-3.5 mg/kg bolus)	Miscellaneous	<input type="checkbox"/> Joltes Synchronized	<input type="button" value="Screen 1"/>
<input type="checkbox"/> Procainamide Infusion <input type="text"/> mg/min (20-30 mg/min up to 17 mg/kg)	<input type="checkbox"/> Magnesium <input type="text"/> gm (1-2 gm 50% MgSO ₄ in 10 ml of D5W over 1-2 min)	<input type="checkbox"/> Sodium Bicarbonate <input type="text"/> mEq (1 mEq/kg)	<input type="button" value="Meds 2"/>
<input type="checkbox"/> Procainamide Infusion <input type="text"/> mg/min (17 mg/kg in 1st hr, then 2.8 mg/kg/hr) (NOTE: discontinue if hypotensive, if QRS, PR or QT > 150% of baseline)	<input type="checkbox"/> Calcium Chloride <input type="text"/> cc 10% soln (0.1 cc/kg)	<input type="checkbox"/> Morphine <input type="text"/> mg IV slow (1-3 mg/dose and titrate to effect)	<input type="button" value="Rhythm"/>
<input type="checkbox"/> Bretylium <input type="text"/> mg (5 mg/kg, then 10 mg/kg, upper limit 35 mg/kg)	<input type="checkbox"/> Deserol <input type="text"/> mg IV slow	<input type="checkbox"/> Ddauid <input type="text"/> mg IV slow	<input type="button" value="Exit No-Save"/>
<input type="checkbox"/> Bretylium Infusion <input type="text"/> mg/min (2 mg/min)	<input type="checkbox"/> Narcan <input type="text"/> mg IV (0.4-1.0 mg)	<input type="checkbox"/> D50W	<input type="button" value="Clear User"/>
			<input type="button" value="Exit"/>

Figure Chapter 3: -98: ACLS/CPR - Medications 1

(Image: acls-cpr-1.bmp)

5b. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on Screen 1, Meds 1, Meds 2 and/or Rhythm buttons to access additional ACLS/CPR screens.



6. Click the Exit button to save updated patient information.

ACLS/CPR: Medications 2

ACLS/CPR - Medications 2 Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Requested by: J.E. Ross, MD

Inotropic/Vasoactive Agents	Beta-Adrenergic Blockers	Given/Performed	History of ACLS
<input type="checkbox"/> Epinephrine <input type="text"/> mg IV (0.5-1.0 mg initial, up to 5 mg second dose)	<input type="checkbox"/> Propranolol <input type="text"/> mg IV slow over 2-5 min (1-3 mg/dose up to 0.1 mg/kg total)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Norepinephrine Infusion <input type="text"/> mcg/min (0.5-1 initial, up to 30 mcg/min)	<input type="checkbox"/> Metoprolol <input type="text"/> mg IV over 2-5 min (5 mg, may repeat q 5 min to 15 mg total)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dopamine Infusion <input type="text"/> mcg/kg/min (1-5 initial, up to 30 mcg/kg/min)	<input type="checkbox"/> Atenolol <input type="text"/> mg IV over 5 min (5 mg, may repeat once after 10 min)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dobutamine Infusion <input type="text"/> mcg/kg/min (2 mcg/kg/min initial, up to 30 mcg/kg/min)	<input type="checkbox"/> Esmolol Loading <input type="text"/> mcg/kg/min for only 1 min (250-500 mcg/kg/min)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Isoproterenol Infusion <input type="text"/> mcg/min (2-10 mcg/min)	<input type="checkbox"/> Esmolol Infusion <input type="text"/> mcg/kg/min (25-50 initial, up to 300 mcg/kg/min max)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Amrinone Infusion <input type="text"/> mcg/kg/min (2-15 mcg/kg/min)	Diuretics	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Digoxin <input type="text"/> mg IV slow (10-15 mcg/kg loading dose)	<input type="checkbox"/> Furosemide <input type="text"/> mg IV slow (0.5-1.0 mg/kg initial, up to 2 mg/kg total)	<input type="text"/>	<input type="text"/>
Vasodilators/Antihypertensives	Thrombolytic Agents	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Nitroglycerine Infusion <input type="text"/> mcg/min (10 initial, titrate to 50-200 max)	<input type="checkbox"/> Anistreplase Protocol Initiated (See hospital form)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Nitroglycerine Sublingual <input type="text"/> mg (0.3-0.4 mg, may repeat q 5 min)	<input type="checkbox"/> Streptokinase Protocol Initiated (See hospital form)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Sodium Nitroprusside <input type="text"/> mcg/kg/min (0.1 initial, titrate up to 8.0 max)	<input type="checkbox"/> TPA (Alteplase) Protocol Initiated (See hospital form)	<input type="text"/>	<input type="text"/>
	Defibrillation/Cardioversion	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Joules Non-Synchronized <input type="text"/> (200-400 Adult, 2-4 J/kg Child)	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Joules Synchronized <input type="text"/> (25-400 Adult, 2 J/kg Child)	<input type="text"/>	<input type="text"/>

Weight: ☐ Estimated 129 lbs 59 kg

After each medication or procedure is given/performed, press "Given/Performed" to record timing of events.

To view sequence of events and times, press "History of ACLS"

Screen 1
 Meds 1
 Rhythm
 Exit No Save
 Clear User
 Exit

Figure Chapter 3: -99: ACLS/CPR - Medications 2

(Image: acls-cpr-medications2.bmp)

5c. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on Screen 1, Meds 1 and/or Rhythm buttons to access additional ACLS/CPR screens.



6. Click the Exit button to save updated patient information.

ACLS/CPR: Rhythm

ACLS/CPR - Rhythm Active User J.E. Ross, MD

Patient Name Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Requested by J.E. Ross, MD

Rhythm	Given/Performed	History of ACLS
<input type="checkbox"/> Undetermined Rhythm	<input type="checkbox"/> Electronic Pacemaker Rhythm (Ventricular Type)	<p>After each medication or procedure is given/performed press "Given/Performed" to record timing of events</p> <p>To view sequence of events and times, press "History of ACLS"</p> <p>Screen 1</p> <p>Meds 1</p> <p>Meds 2</p> <p>Exit No-Save</p> <p>Clear User</p> <p>Exit</p>
<input type="checkbox"/> Normal Sinus Rhythm (NSR)	<input type="checkbox"/> Electronic Pacemaker Rhythm (AV Sequential Type)	
<input type="checkbox"/> Normal Sinus Rhythm w/Sinus Arrhythmia	<input type="checkbox"/> Torsade de Pointes	
<input type="checkbox"/> Sinus Bradycardia		
<input type="checkbox"/> Sinus Tachycardia		
<input type="checkbox"/> Supraventricular Tachycardia (SVT)		
<input type="checkbox"/> Paroxysmal Supraventricular Tachycardia (PSVT)		
<input type="checkbox"/> Junctional Tachycardia		
<input type="checkbox"/> Junctional Tachycardia w/Retrograde P Waves		
<input type="checkbox"/> Junctional Escape w/Retrograde P Waves		
<input type="checkbox"/> Junctional Escape w/Ventricular Aberrancy		
<input type="checkbox"/> Ectopic Atrial Pacemaker		
<input type="checkbox"/> Supraventricular Tachycardia (SVT) w/Short PR Interval		
<input type="checkbox"/> Atrial Fibrillation w/Ventricular Rate < 100		
<input type="checkbox"/> Atrial Fibrillation w/Rapid Ventricular Response		
<input type="checkbox"/> Atrial Flutter		
<input type="checkbox"/> Atrial Flutter w/Variable AV Block		
<input type="checkbox"/> Idioventricular Rhythm		
<input type="checkbox"/> Accelerated Idioventricular Rhythm		
<input type="checkbox"/> Ventricular Tachycardia		
<input type="checkbox"/> Wide Complex Tachycardia		
<input type="checkbox"/> Ventricular Fibrillation		
<input type="checkbox"/> Asystole		
<input type="checkbox"/> PEA (EMD)		

Pacing

☐ External Pacing Applied

☐ Capture Was Obtained

☐ Capture Was Not Obtained

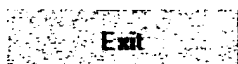
Comment:

Figure Chapter 3: -100: ACLS/CPR - Rhythm

(Image: acls-cpr-rhythm.bmp)

5a. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on **Screen 1**, **Meds 1**, and/or **Meds 2** buttons to access additional ACLS/CPR screens.



6a. Click the **Exit** button to save updated patient information.

Ordering/Documenting Diagnostic Procedures (std. menu)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Diagnostic Procedures

3. Click on the Diagnostic Procedures button in the INPUT section.
4. Select the appropriate Procedure. (Eye Exam/Treatment sample follows)

Diagnostic Procedures		Active User: J.E.Ross, MD
Anoscopy	Umbilical Artery Catheter	
Arterial Line		
Arthrocentesis		
Bladder Aspiration		
Caloric Testing		
Central Line		
Culdocentesis		
Eye Exam		
Foley		
Gastric Lavage		
In & Out Catheterization		
Joint Aspiration		
Laryngoscopy		
Lumbar Puncture		
Monitoring		
Myasthenia Gravis Testing		
Nasogastric Tube		
Observation		
Paracentesis		
Pelvic Exam		
Pericardiocentesis		
Peritoneal Lavage		
Rape Exam		
Rectal Exam		
Sigmoidoscopy		
Slit Lamp Exam		
Thoracentesis		
Tonometry		

Common Nurse Orders

Date: 02/11/97
Time: 13:35

Diagnostic Procedures

Medications/IV Solutions

Therapeutic Procedures

Exit No-Save

Clear User

Exit

Figure Chapter 3: -101: Diagnostic Procedures

(Image: diagnostic-procedures.bmp)

Exit

5. Click the Exit button to save updated patient information.

Diagnostic Procedures Screen: Eye Exam/Treatment

Eye Exam/Treatment		Active User J.E. Ross, MD	
Patient Name: Byrd, Newby Adm # K226534749 Pat # K226534749 SS # Bed 01			
Requested by J.E. Ross, MD		Weight	
Dilation <input type="checkbox"/> Neo-Synephrine (Phenylephrine 2.5%) <input type="checkbox"/> Homatropine 5% <input type="checkbox"/> Cyclogyl (Cyclopentolate 1%) <input type="checkbox"/> Mydracyl (Tropicamide 1%)		<input type="checkbox"/> Estimated <input type="text"/> lbs <input type="text"/> kg	
Fluorescein <input type="checkbox"/> Abrasions <input type="checkbox"/> Foreign Body <input type="checkbox"/> Keratitis (Dendrites) <input type="checkbox"/> Anterior Chamber Fluorescein Flare <input type="checkbox"/> Positive Seidel Test (Blue or Green Stream) <input type="checkbox"/> Corneal Burns (Pits)		Antibiotic <input type="checkbox"/> Gentamycin <input type="checkbox"/> Tobramycin <input type="checkbox"/> Sulfacetamide <input type="checkbox"/> Erythromycin <input type="checkbox"/> Polysporin <input type="checkbox"/> Neosporin	
Topical Anesthesia <input type="checkbox"/> Pontocaine (Tetracaine) <input type="checkbox"/> Alcaine/Ophthaine/Ophthetic (Proparacaine) <input type="checkbox"/> Dorsacaine (Benoxinate)		Patient Instructions <input type="checkbox"/> Eyedrop Use <input type="checkbox"/> Socket Trauma <input type="checkbox"/> Chemicals in <input type="checkbox"/> Conjunctival FB <input type="checkbox"/> Conjunctivitis	
Eye Irrigation <input type="checkbox"/> Normal Saline for Irrigation, 500 cc <input type="checkbox"/> Normal Saline for Irrigation, 1000 cc <input type="checkbox"/> Morgan Therapeutic Lens <input type="checkbox"/> Lid Eversion <input type="checkbox"/> Conjunctival Fornix Foreign Body Removal		<input type="checkbox"/> = Completed If checked, will not print instructions to perform.	
Cycloplegic <input type="checkbox"/> Homatropine 5% <input type="checkbox"/> Cyclogyl (Cyclopentolate 1%)		<input type="checkbox"/> Exit No-Save	
Foreign Body Removal <input type="checkbox"/> Conjunctival <input type="checkbox"/> Eyelid <input type="checkbox"/> Cornea <input type="checkbox"/> Rust Ring Removal		<input type="checkbox"/> Eye Shield <input type="checkbox"/> Donaldson Eye Patch	
Eye Patches <input type="checkbox"/> Double Patches		<input type="checkbox"/> Contact Lens Removal <input type="checkbox"/> Done	
Slit Lamp Exam <input type="checkbox"/> Anterior Chamber Cells <input type="checkbox"/> Anterior Chamber Flare <input type="checkbox"/> Corneal Abrasion <input type="checkbox"/> Corneal Perforation <input type="checkbox"/> Lens Dislocation <input type="checkbox"/> Hordeolum <input type="checkbox"/> Blepharitis <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Hyphema		Tonometry <input type="checkbox"/> Schiotz (Impression) <input type="checkbox"/> Goldmann (Applanation) <input type="checkbox"/> Tono-Pen <input type="checkbox"/> Pressure <input type="text"/> L <input type="text"/> R cm H2O (12-18 Normal)	
<input type="checkbox"/> Hypertension		Patient Instructions <input type="checkbox"/> Corneal Abrasion <input type="checkbox"/> Corneal FB <input type="checkbox"/> Corneal FB w/Rust <input type="checkbox"/> Corneal Ulceration <input type="checkbox"/> Contact Lens <input type="checkbox"/> Corneal UV Burn <input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Clear User		<input type="checkbox"/> Exit	

Figure Chapter 3: -102: Eye Exam/Treatment

(Image: eye-exam-treatment.bmp)

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Entering Procedures & Therapeutics Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Procedures & Therapeutics comment entry:

- Click on To Add button.
- Open the pull down menu and select "Procedures & Therapeutics".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD
 Received: / / Dictated: 02/19/97 10:47 Add More

Patient Verification
 Name: Garbo, Greta
 Adm # 1895752
 Pat # 7564552

Text 2 of 2

Category

- Patient Identification and Statistics**
- Labs
- Tests
- X-Rays
- Procedures & Therapeutics**
- ED Course
- Chart Review
- Differential Diagnosis

Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -103: Procedures & Therapeutics (in Editor Add Mode)

(Image: editor-add-mode-5.bmp)

Entering/Modifying Procedures & Therapeutics comments (manual) (continued)

4b. Modify an existing Procedures & Therapeutics comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Procedures & Therapeutics.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD

Received: / /

Dictated: 02/12/97 12:50

Patient Verification

Name: Garbo, Greta

Adm #: 1895752

Pat #: 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

Buttons on the right:

- To Add
- Prior
- Next
- First
- Last
- Delete
- Edit Header
- Exit No-Save
- Clear User
- Exit

Figure Chapter 3: -104: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Procedures & Therapeutics

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Therapeutics Summary

3. Click on the Therapeutics Summary button in the HISTORICAL section.

Therapeutics Summary			Active User: James Ross, Jr., MD	
Patient Name: Byrd, Fickle	Adm #: G16534459	Pat #: 16548	SS #	Bed: Unknown
<p>Procedures & Therapeutics</p> <p>ACLS actions included:</p> <p>02/03/97 10:32:54 CPR - External chest compression.</p> <p>02/03/97 10:33:02 Defib/Cardioversion - 200 joules non-synchronized.</p> <p>02/03/97 10:33:12 Rhythm - sinus bradycardia.</p> <p>02/03/97 10:33:23 Meds - Epinephrine 1.00 mg.</p> <p>01/08/97 13:58</p> <p>Ordered Biaxin 500 MG, Clarithromycin Tablet: 1 tab po Ordered now.</p> <p>02/03/97 10:28</p> <p>Burn wound management included the following: sterile sheets were applied, the burn was cleansed with soap solution and a non-adherent burn dressing was applied.</p>				
<p>Print Apply Signature Remove Signature Clear User Exit</p>				

Figure Chapter 3: -105: Therapeutics Summary

(Image: therapeutics-summary.bmp)

Exit

4. Click the Exit button (twice) to return to the Medical Information screen.

Viewing Procedures & Therapeutics (continued)

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary		Active User: James Ross, Jr., MD	
Patient Name: Byrd, Binkie	Adm #: E107576349	Pat #: F97588089	SS #: Bed Unknown
Tests 08/13/97 10:38 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates no acute ischemic change. 08/13/97 10:56 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates T wave inversion. 09/08/97 10:50 EKG analyzed by James Ross, Jr., MD. The EKG demonstrates no acute ischemic change and T wave inversion.			
Procedures & Therapeutics Laceration repairs include: Laceration number 1 dermis layer (length 24 cm). To clean the laceration, Betadine solution was used. Irrigation was performed using a syringe and catheter and normal saline. Steri-strips were applied. Laceration number 1 subcutaneous tissue (length 4 cm). To clean the laceration, Betadine scrub was used. Irrigation was performed using a Zero-Wet splash shield and 10% Betadine in normal saline. 06/11/97 16:45 D5W was administered as a 1000 cc bolus. 09/10/97 14:15 A nasogastric tube was inserted using a Levin tube. Tube suction was set to low intermittent suction. 09/10/97 14:25 A hard collar was placed on the patient to provide cervical restraint. Upper extremity immobilization was obtained using a rigid splint. The patient was placed in a reverse Trendelenburg position. 09/15/97 14:01 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf countertraction, anterior pressure on the foot with posterior pressure on the distal tibia. The anterior ankle dislocation was reduced using knee flexion at 30°, foot traction, calf countertraction and anterior pressure on the distal tibia with posterior pressure on the foot. 09/15/97 14:31 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf			
Print	Apply Signature	Remove Signature	Clear User Exit

Figure Chapter 3: -106: Medical Record Summary

(Image: medical-record-summary-5.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Documenting Therapeutic Procedures

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Therapeutic Procedures (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- ***Alternate access to these screens***
Therapeutics & Diagnostic Procedures & Medications screens

Medications in the ER

Ordering Medications in the ER - Drugs (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Medications in ER

3. Click on the Medications in ER button in the INPUT section.

4. Select the appropriate Drugs(s) from the Select Drug screen. (Keflet sample follows)

Select Drug Active User: J.E. Ross, MD

Tetanus-expired Pregnant Allergies Demerol sulfa

ALUPENT INH	Drudis 75 MG
Amoxicillin 125 MG/5ML	Phenergan Supp 25 MG
Amoxicillin 250 MG Chewable	Proventil Inhaler
Amoxicillin 250 MG/5ML	Relafen 500 MG
Amoxicillin 500 MG	Theo-24 300 MG
Biaxin 250 MG	Theo-Dur 200 MG
Biaxin 500 MG	Tylenol #3 300-30MG
Ceclor 125 MG/5ML	Tylenol Jr Chewable 160 MG
Ceclor 250 MG	Vicodin 7.5mg
Ceclor 250 MG/5ML	Zithromax 250 MG
Ceclor 500 MG	
Cipro 500 MG	
Darvocet-N 1 00	
Dilantin 100 MG	
Doxycycline 100 MG	
Duricef 500 MG, skin	
Flagyl Trich	
Gaviscon-2	
Keflet for skin	
Keflex 500 MG, q6h10d	
Lanoxin 0.125 MG	
Lanoxin 0.25 MG	
Lorabid 200 MG	
Macrobid Cap 100 MG	
Naprosyn 375 MG	
Naprosyn 500 MG	
Orudis 50 MG	

Alphabetical Drug List Classification Drug List Custom Clear User Exit

Figure Chapter 3: -107: Select Drug

(Image: select-drug.bmp)

Exit

5. Click the Exit button to save updated patient information.

Medications in the ER: Keflet Screen

Tetanus expired. Pregnant Allergies: Demerol, sulfa

No.	Type	Route	Frequency	Duration
1/4	tab	po	1 time only	1 day
1/2	cap	pr	q day	2 days
3/4	inch	os	bid	3 days
1	lozenge	od	tid	4 days
2	ampule	ou	qid	5 days
3	packet	as	5 times daily	7 days
4	supp	ad	q 3*	10 days
5	piece	au	q 3-4*	12 days
6	implant	inhalations	q 3-6*	14 days
7	patch	intranasal	q 3-12*	21 days
8	bar	apply to affect. area	q 4*	28 days
9	bottle	topically	q 4-6*	30 days
10	gtts	sublingual	q 4-8*	
	tsp	vaginal	q 5*	
<input type="checkbox"/> + 1/2	tbs	as irrigation	q 6*	
	cc	transdermal	q 6-8*	
	mcg	IM	q 6-12*	
	mg	IV	q 8*	
	gms	subcutaneous	q 8-12*	
	ml		q 12*	
	mmu			
	mu			
	u			
	units			

☐ As Needed

To add 1/2 to the No. (i.e. 3 1/2)
click the box on "+ 1/2" then
click the appropriate No. button.

Drug Name
Keflet 500 MG

Generic
Cephalexin Tab

Drug Group

Drug Subgroup

Drug Class

Quantity

Refills ☐ Refills PRN

Duration Days

SIG (Use Option Return to manually break lines)

1 tab po bid

☒ Selection Permitted
☐ Dispense As Written

Figure Chapter 3: -108: Typical Drug Selection Screen

(Image: prescription-keflet.bmp)

Entering Medications in the ER Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Medications comment entry:

- Click on To Add button.
- Open the pull down menu and select "Medications".

Editor - Add Mode Active User J.E. Ross, MD

Patient Name: Byrd, Newby

Adm # K226534749 Pat # K226534749 SS # Bed 01

Dictator: Ross MD
 Received: / /
 Dictated: 02/12/97 10:50

Patient Verification
 Name: Byrd, Newby
 Adm #: K226534749
 Pat #: K226534749

Text 1 of 1

Category

- Patient Identification and Statistics
- Patient Identification and Statistics
- Chief Complaint
- History of Present Illness
- Medications
- Allergies
- Past Medical History
- Previous Hospitalizations

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -110: Medications (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Medications in the ER comments (manual) (continued)

4b. Modify an existing Medications comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Medications.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD Received: / / Dictated: 02/12/97 12:50

Patient Verification: Name: Garbo, Greta Text 2 of 2

Adm #: 1895752 Pat #: 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -111: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Medications in the ER

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Therapeutics Summary

3. Click on the Therapeutics Summary button in the HISTORICAL section.

Therapeutics Summary		Active User J.E. Ross, MD	
Patient Name Smith, Christina			
Adm # B197505859	Pat # F25640236	SS # 123456789	Bed 06

Procedures & Therapeutics

02/19/97 14:05
Administered Orudis 75 MG, Ketoprofen Capsule: 1 tab now.

02/19/97 14:20
For splinting a simple ace wrap was applied.

Page 1
Last

Previous

Next

Clear User

Exit

Figure Chapter 3: -112: Therapeutics Summary (with Medications in ER)

(Image: therapeutics-summary.bmp)

Exit

4. Click the Exit button (twice) to return to the Medical Information screen.

Viewing Medication in the ER (continued)

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name	Byrd, Binkie			
Adm #	F107576349	Pat #	F97588089	SS #
				Bed: Unknown
<p>Tests</p> <p>08/13/97 10:38 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates no acute ischemic change.</p> <p>08/13/97 10:56 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates T wave inversion.</p> <p>09/08/97 10:50 EKG analyzed by James Ross, Jr., MD. The EKG demonstrates no acute ischemic change and T wave inversion.</p> <p>Procedures & Therapeutics</p> <p>Laceration repairs include: Laceration number 1 dermis layer (length 24 cm). To clean the laceration, Betadine solution was used. Irrigation was performed using a syringe and catheter and normal saline. Steri-strips were applied.</p> <p>Laceration number 1 subcutaneous tissue (length 4 cm). To clean the laceration, Betadine scrub was used. Irrigation was performed using a Zero-Wet splash shield and 10% Betadine in normal saline.</p> <p>06/11/97 16:45 D5W was administered as a 1000 cc bolus.</p> <p>09/10/97 14:15 A nasogastric tube was inserted using a Levin tube. Tube suction was set to low intermittent suction.</p> <p>09/10/97 14:25 A hard collar was placed on the patient to provide cervical restraint. Upper extremity immobilization was obtained using a rigid splint. The patient was placed in a reverse Trendelenburg position.</p> <p>09/15/97 14:01 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf countertraction, anterior pressure on the foot with posterior pressure on the distal tibia. The anterior ankle dislocation was reduced using knee flexion at 30°, foot traction, calf countertraction and anterior pressure on the distal tibia with posterior pressure on the foot.</p> <p>09/15/97 14:31 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf</p>				
Print		Apply Signature		Remove Signature
		Clear User		Exit

Figure Chapter 3: -113: Medical Record Summary

(Image: medical-record-summary-5.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Ordering Medications in the ER

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Medications (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- ***Alternate access to these screens***
Therapeutics & Diagnostic Procedures screens

Page Intentionally Left Blank

Referrals

Entering/Updating Referrals (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Referrals

3. Click on the Referrals button in the INPUT section.

Refer To Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Look Up **More**

Name:

Specialty:

Firm:

Address:

City, St, Zip:

Office Phone:

Appointment Date: Appointment Time:

Appointment In:

Figure Chapter 3: -114: Refer To

(Image: refer-to.bmp)

Entering/Updating Referrals (std. menu) (continued)**4a. Entering a new referral:****Look Up**

- Select form fields and complete as appropriate.
- Select Appointment in (via button or manual).
- The Look Up button provides an updateable list of local “referrals”.

Referral Log**4b. Updating an existing referral:****Edit**

- Click on the Referral Log button.
- Highlight the “referred to” name.
- Click the Edit button and update the form fields as required (see 4a.).

Referral Log Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-01-9873 Bed: 02

Bebe T Newbirth
 Leslie F Ammeter

See Detail

Delete

Referral Input

Edit

Clear User

Exit

Name: Bebe T Newbirth
 Specialty: OB-GYN
 Firm: Babies Are Us
 Address: 1656 Avalon Circle
 Suite #344
 City, St, Zip: San Antonio, TX 78229
 Office Phone: (210) 377-3366
 Appointment Date: 09/10/96 Appointment Time:

Figure Chapter 3: -115: Referral Log

(Image: referral-log.bmp)

Exit

5. Click the Exit button to save updated referral information.

Entering/Updating Referrals Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Referrals comment entry:

- Click on To Add button.
- Open the pull down menu and select "Referrals".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby

Adm #: K226534749 Pat #: K226534749 SS #: Bed: 01

Dictator: Ross MD

Received: / / Dictated: 02/14/97 11:47 Add More

Patient Verification:

Name: Byrd, Newby

Adm #: K226534749

Pat #: K226534749

Text 1 of 1

Category:

- Patient Identification and Statistics
- Differential Diagnosis
- Results of Therapy & Complications
- Interval Exams
- Consultations
- Diagnosis
- Referrals
- Counseling

Exit No-Save

Clear User

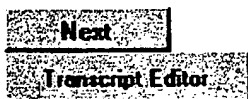
Exit

Figure Chapter 3: -116: Referrals (in Editor Add Mode)

(Image: editor-add-mode-4.bmp)

Entering/Modifying Referral Comments (manual) (continued)

4b. Modify an existing Referrals comment entry:



- Click on Next / Prior (or First / Last) buttons to locate Referrals.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

 The screenshot shows a software window titled 'Editor - View Mode'. At the top right, it says 'Active User: J.E. Ross, MD'. Below this, patient information is displayed: 'Patient Name: Greta Garbo', 'Adm #: 1895752', 'Pat #: 7564552', 'SS #: 450-81-9873', and 'Bed: 02'. On the left side, there is a section for 'Dictator: Ross MD' with 'Received: / /' and 'Dictated: 02/12/97 12:50'. Below that is 'Patient Verification' with 'Name: Garbo, Greta', 'Adm #: 1895752', and 'Pat #: 7564552'. A large text area in the center contains the placeholder text 'Manually/Custom entered text will appear here'. Above this text area is a button labeled 'Use buttons to select category -->'. On the right side of the window, there is a vertical column of buttons: 'To Add', 'Prior', 'Next', 'First', 'Last', 'Delete', 'Edit Header', 'Exit No-Save', 'Clear User', and 'Exit'.

Figure Chapter 3: -117: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)



6. Click the Exit button to save updated patient information.

Viewing Referrals

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Referral Log

3. Click on the Referral Log button in the HISTORICAL section.

Referral Log Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Babe T Newbirth
Leslie F Ammeter

Name: Babe T Newbirth
Specialty: OB-GYN
Firm: Babies Are Us
Address: 1656 Avalon Circle
Suite #344
City, St, Zip: San Antonio, TX 78229
Office Phone: (210) 377-3366
Appointment Date: 09/10/96 Appointment Time:

See Detail

Delete

Referral Input

Edit

Clear User

Exit

Figure Chapter 3: -118: Referral Log

(Image: referral-log.bmp)

See Detail

Exit

4. Highlight the "referred to" name.

5. Click on the See Detail button.

6. Click the Exit button to return to the Medical Information screen.

Viewing Referrals (continued)

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Referrals

3. Click on the Referrals button in the INPUT section.

Referral Log

4. Click on the Referral Log button

Referral Log Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Babe T Newbirth
 Leslie F Ammeter

Name: Babe T Newbirth
 Specialty: OB-GYN
 Firm: Babies Are Us
 Address: 1656 Avalon Circle
 Suite #344
 City, St, Zip: San Antonio, TX 78229
 Office Phone: (210) 377-3366
 Appointment Date: 09/10/96 Appointment Time:

See Detail

Delete

Referral Input

Edit

Clear User

Exit

Figure Chapter 3: -119: Referral Log

(Image: referral-log.bmp)

See Detail

Exit

5. Highlight the "referred to" name.
6. Click on the See Detail button.
7. Click the Exit button to return to the Medical Information screen.

Viewing Referrals (continued)**→ Option C***From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name	Byrd, Binkie			
Adm #	F107576349	Pat #	F97588089	SS #
				Bed Unknown
Tests 08/13/97 10:38 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates no acute ischemic change. 08/13/97 10:56 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates T wave inversion. 09/08/97 10:50 EKG analyzed by James Ross, Jr., MD. The EKG demonstrates no acute ischemic change and T wave inversion.				
Procedures & Therapeutics Laceration repairs include: Laceration number 1 dermis layer (length 24 cm). To clean the laceration, Betadine solution was used. Irrigation was performed using a syringe and catheter and normal saline. Steri-strips were applied. Laceration number 1 subcutaneous tissue (length 4 cm). To clean the laceration, Betadine scrub was used. Irrigation was performed using a Zero-Wet splash shield and 10% Betadine in normal saline. 06/11/97 16:45 D5W was administered as a 1000 cc bolus. 09/10/97 14:15 A nasogastric tube was inserted using a Levin tube. Tube suction was set to low intermittent suction. 09/10/97 14:25 A hard collar was placed on the patient to provide cervical restraint. Upper extremity immobilization was obtained using a rigid splint. The patient was placed in a reverse Trendelenburg position. 09/15/97 14:01 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf countertraction, anterior pressure on the foot with posterior pressure on the distal tibia. The anterior ankle dislocation was reduced using knee flexion at 30°, foot traction, calf countertraction and anterior pressure on the distal tibia with posterior pressure on the foot. 09/15/97 14:31 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf				
Print	Apply Signature	Remove Signature	Clear User	Exit

Figure Chapter 3: -120: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Referrals

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Referrals (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Consultations

Entering/Documenting Consultations (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Consultations

3. Click on the Consultations button in the INPUT section.

Consultations Active User James Ross, Jr., MD

Patient Name Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

ED Doctor A

Consultant Look Up

Specialty

Date Called Time Called A

Date Resp Time Resp A

Comment

Consultant Type

☐ On Call Physician

☐ Patient's Private Physician

☐ Private Referred Physician

☐ Other Physician

☐ Organ Donor Team

☐ Social Worker

☐ Detox Team

☐ Chaplain

☐ Police

☐ Other

☐ Unknown

Add Case was discussed at length

Add Concurs with decision to admit patient and has given orders.

Add Concurs with decision to admit patient and floor will call for orders.

Add Is coming to see patient.

Add Wishes the patient to be referred to Dr.

Add Wishes to see the patient

Add Wishes to transfer the patient to

Add Case was discussed, consultant concurs with the decision to discharge patient.

Add Called office.

Add Called exchange.

Add Called home.

Add Called beeper.

Consultation Log

Exit No-Save

Clear User

Exit

Figure Chapter 3: -121: Consultations

(Image: consultations.bmp)

Entering/Documenting Consultations (std. menu) (continued)**4a. Entering a new consultation:****Add**

- Select form fields and Add buttons as appropriate and complete.

Look Up

- The Look Up button provides an updateable list of local “consultants”.

Consultation Log**4b. Update an existing consultation:****Edit**

- Click on the Consultation Log button in the HISTORY section.
- Highlight the “consultant” name.
- Click the Edit button and update the form fields as required.

Consultations Active User: J.E. Ross, MD

Patient Name: Byrd, Newby
 Adm # K226534749 Pat # K226534749 SS # Bed 01

Consultant	Time Requested	Has Responded
D.C. Washington, MD	15:00	Y

To see consultation details, double click on consultant name
or
click on consultant name then click "Show Detail"
To edit consultation click on consultant name then click "Edit"

Show Detail **Edit**

Consultant: D.C. Washington, MD
 Specialty: E.D. Doctor J.E. Ross, MD
 Date Called: 11/22/96 Time Called: 15:00
 Date Resp: 11/22/96 Time Resp: 15:00
 Comment: Private Referred Physician
 The case was discussed at length. Consultant wishes to see the patient

Clear User
Exit

Figure Chapter 3: -122: Consultation Log

(Image: consultation-log.bmp)

Exit

5. Click the Exit button to save updated consultation information.

Entering/Updating Consultations Comments (manual)

From the “Active Patient List” (your main tracking screen)

1. Select a patient from the “Grease Board” (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Consultations comment entry:

- Click on To Add button.
- Open the pull down menu and select “Consultations”.

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Byrd, Newby
 Adm #: K226534749 Pat #: K226534749 SS # Bed 01

Dictator: Ross MD
 Received: / / Dictated: 02/14/97 11:47 Add More

Patient Verification
 Name: Byrd, Newby
 Adm #: K226534749
 Pat #: K226534749

Text 1 of 1

Category

- Patient Identification and Statistics
- Differential Diagnosis
- Results of Therapy & Complications
- Interval Exams
- Consultations
- Diagnosis
- Referrals
- Counseling

Exit No-Save
Clear User
Exit

Figure Chapter 3: -123: Consultations (in Editor Add Mode)

(Image: editor-add-mode-4.bmp)

Entering/Modifying Consultations Comments (manual) (continued)

4b. Modify an existing Consultations comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Consultations.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: // Dictated: 02/12/97 12:50
 Patient Verification
 Name: Garbo, Greta Text 2 of 2
 Adm #: 1895752
 Pat #: 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -124: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Consultations (continued)

→ Option C

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name: Byrd, Binkie	Adm #: F107576349	Pat #: F97588089	SS #	Bed: Unknown
Tests 08/13/97 10:38 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates no acute ischemic change. 08/13/97 10:56 EKG analyzed by James Ross, Jr., MD. An old EKG was not available for comparison. The EKG demonstrates T wave inversion. 09/08/97 10:50 EKG analyzed by James Ross, Jr., MD. The EKG demonstrates no acute ischemic change and T wave inversion.				
Procedures & Therapeutics Laceration repairs include: Laceration number 1 dermis layer (length 24 cm). To clean the laceration, Betadine solution was used. Irrigation was performed using a syringe and catheter and normal saline. Steri-strips were applied. Laceration number 1 subcutaneous tissue (length 4 cm). To clean the laceration, Betadine scrub was used. Irrigation was performed using a Zero-Wet splash shield and 10% Betadine in normal saline. 06/11/97 16:45 D5W was administered as a 1000 cc bolus. 09/10/97 14:15 A nasogastric tube was inserted using a Levin tube. Tube suction was set to low intermittent suction. 09/10/97 14:25 A hard collar was placed on the patient to provide cervical restraint. Upper extremity immobilization was obtained using a rigid splint. The patient was placed in a reverse Trendelenburg position. 09/15/97 14:01 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf countertraction, anterior pressure on the foot with posterior pressure on the distal tibia. The anterior ankle dislocation was reduced using knee flexion at 30°, foot traction, calf countertraction and anterior pressure on the distal tibia with posterior pressure on the foot. 09/15/97 14:31 The posterior ankle dislocation was reduced by flexing the knee to 30-45°, followed by traction on the foot, calf				
Print	Apply Signature	Remove Signature	Clear User	Exit

Figure Chapter 3: -127: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Consultation

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Consultations (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Viewing Physician/Patient Encounters Log

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Dr. Interval

3. Click the Dr. Interval button in the HISTORICAL section.

Doctor Interval Active User: James Ross, Jr., MD

Patient Name: Smith, Jj Pat #: 1307433899 SS #: Bed: Unknown

Date	Time	Doctor
09/30/1997	12:03	James Ross, Jr., MD
09/30/1997	12:06	James Ross, Jr., MD

2 Entries

Clear User

Exit

Figure Chapter 3: -131: Doctor Interval

(Image: doctor-interval.bmp)

Exit

5. Click the Exit button to save updated patient information.

Tips and Hints: Logging Physician/Patient Encounters & Interval Exams

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Interval Exams comment text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Entering/Updating Prescriptions Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Prescriptions comment entry:

- Click on To Add button.
- Open the pull down menu and select "Prescriptions".

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: // Dictated: 02/20/97 13:31

Patient Verification:
 Name: Garbo, Greta
 Adm #: 1895752
 Pat #: 7564552

Text 2 of 2

Category:

- Patient Identification and Statistics
- Diagnosis
- Referrals
- Counseling
- Prescriptions
- Work/School Limitations/Excuse
- Discharge
- Neuro Assessment

Add More

Exit No-Save

Clear User

Exit

Figure Chapter 3: -134: Prescriptions (in Editor Add Mode)

(Image: editor-add-mode-6.bmp)

Entering/Modifying Prescriptions Comments (manual) (continued)

4b. Modify an existing Prescriptions comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Prescriptions.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD
 Received: / / Dictated: 02/12/97 12:50
 Patient Verification
 Name: Garbo, Greta
 Adm # 1895752
 Pat # 7564552

Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -135: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Viewing Prescribed Medications

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Prescribed Meds

3. Click on Prescribed Meds button in HISTORICAL section.

Prescription Meds Summary Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Date	Prescribed Med
09/08/96	Amoxicillin 500 MG

1 Prescriptions

To show detail on a prescription double click on the "Date" or "Prescribed Med" or click on the "Date" or "Prescribed Med" and click "Show Detail"

Detail Show Detail

Adm # 146853989	Pat # 7564552	SIG
Date: 09/08/96	Time 12:04	Days 10
Doctor: J.E. Ross, MD	1 capsule every 8 hours	
Drug: Amoxicillin 500 MG		
Quantity 30	Refills None	Disp Selection Permitted Y

Figure Chapter 3: -136: Prescription Meds Summary

(Image: prescription-meds-summary.bmp)

4. Click (highlight) one of the drugs listed.

Show Detail

5. Click on the Show Detail button.

Exit

6. Click the Exit button to save updated patient information.

View Prescribed Medications (continued)

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name: Garbo, Greta	Pat # 7564552	SS # 450-81-9873	Bed G5a	
<p>Adm # 1895752</p> <p>Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 121. Respiratory rate: 21.</p> <p>05/15/1997 13:40 Note recorded by J.E. Ross, MD Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 120. Respiratory rate: 21.</p> <p>09/18/1997 14:24 Note recorded by James Ross, Jr., MD</p> <p>09/18/1997 14:24 Note recorded by James Ross, Jr., MD Coma Scale: 14. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: confused. Best motor response: obeys commands. Systolic blood pressure: 135. Respiratory rate: 21. Mrs. Garbo is oriented to time, place and person. The patient is drowsy.</p> <p>09/18/1997 16:02 Note recorded by James Ross, Jr., MD Physician orders completed include: Apply silver sulfadiazine (Silvadene) to burn. Leave burn open. open.</p> <p>09/18/1997 17:11 Note recorded by James Ross, Jr., MD Physician orders completed include: Apply silver sulfadiazine (Silvadene) to burn.</p> <p>William L. Phillips, RN</p> <p>Kelly Townsend, RN</p> <p>James Ross, Jr., MD</p>				
Print		Apply Signature	Remove Signature	Clear User Exit

Figure Chapter 3: -137: Medical Record Summary

(Image: medical-record-summary-6.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Writing Prescriptions

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Prescription comments text into the Medical Record. Go to page 78, “Prephrased Text for the Medical Record”, for more information on the use of Prephrased Text.

Patient Instruction Sets

Queuing Patient Instruction Sets

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Patient Instructions button at the right of screen.

Medical Information

Patient Instructions

Add Patient Instructions Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Double Click on Instruction to Add

- Cellulitis
- Cephalexin
- Cerumen Impaction
- Cervical Collar
- Chemosis
- Chest Pain Of Unclear Cause
- Chest Wall Pain
- Chicken Pox
- Child Welfare Referral
- Child, Ill/? Etiology
- Child, Well
- Child, Well (Illness)
- Child, Well (Injury Check)
- Cholecystogram, Oral Scheduled
- Cholesterol Information
- Ciprofloxacin
- Clear Liquids
- Coccyx Injury
- Colchicine
- Colic
- Concussion
- Concussion Syndrome, Post
- Conjunctival Foreign Body
- Conjunctivitis
- Constipation
- Contusion
- Corneal Abrasion
- Corneal Foreign Body

Complaints

fall

Instructions To Be Printed

Print

Add Clear User

Delete Exit

Figure Chapter 3: -138: Add Patient Instructions

(Image: add-patient-instructions.bmp)

Add

or

Delete

Exit

4. Select (click on) the appropriate instruction(s) from the instructions menu and click on the Add button to place the instruction(s) into the "Instructions to be printed" queue. To remove instruction(s) from the queue, select the instruction(s) then click on the Delete button.
5. Click the Exit button to return to the Medical Information screen.

Work Excuses/School Excuses

Writing a Work Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Work Excuse

3. Click on the Work Excuse button at the right of screen.

Work Excuse Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta SS #: 450-81-9873

Adm #: 1895752 Pat #: 7564552 Bed: 07A

<p>Service Performed</p> <p><input type="checkbox"/> Initial Treatment <input type="checkbox"/> Radiology</p> <p><input type="checkbox"/> Follow-Up Visit <input type="checkbox"/> Lab</p> <p><input type="checkbox"/> Physical Exam <input type="checkbox"/> Physical Therapy</p> <p><input type="checkbox"/> Admitted to Hospital</p> <p>Other: <input style="width: 100%;" type="text"/></p>	<p>Modify Work</p> <p><input type="checkbox"/> Normal Duties (Selection excludes all other work modifications)</p> <p><input type="checkbox"/> No Prolonged Standing or Walking</p> <p><input type="checkbox"/> No Climbing, Bending or Stooping</p> <p><input type="checkbox"/> Limited Use of Left Hand</p> <p><input type="checkbox"/> Limited Use of Right Hand</p> <p><input type="checkbox"/> Left Handed Work Only</p> <p><input type="checkbox"/> Right Handed Work Only</p> <p><input type="checkbox"/> No Work Near Moving Machinery</p> <p><input type="checkbox"/> Keep Wound Clean & Dry</p> <p><input type="checkbox"/> No Exertion For 3 Days</p> <p><input type="checkbox"/> No Exertion For 5 Days</p> <p><input type="checkbox"/> No Exertion For 7 Days</p> <p><input type="checkbox"/> No Exertion For 10 Days</p> <p><input type="checkbox"/> Weight Lifting Restriction To <input style="width: 50px;" type="text"/> lbs.</p> <p>Other: <input style="width: 100%;" type="text"/></p> <p><input type="checkbox"/> Parent With Patient</p>	<p>Referred To</p> <div style="border: 1px solid black; padding: 5px; min-height: 100px;"> <p>Bebe T Newbirth</p> <p>Richard Adam</p> </div>
--	--	---

Exit No-Save

Print

Clear User

Exit

Figure Chapter 3: -139: Work Excuse

(Image: work-excuse.bmp)

4. Click on check boxes and form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Writing a School Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

School Excuse

3. Click on the School Excuse button at the right of screen.

School Excuse Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

School Release

☐ No Competitive Sports

☐ No Physical Education Classes

☐ No School 1 Day

☐ No School 2 Days

☐ No School 3 Days

☐ No School 4 Days

☐ No School 1 Week

☐ No School Return Monday

☐ No School Return until

Date:

Print

Clear User

Exit

Figure Chapter 3: -140: School Excuse

(Image: school-excuse.bmp)

4. Click on check boxes and form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Entering/Updating Work/School Limitations/Excuse Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Work/School Limitations/Excuse comment entry:

- Click on To Add button.
- Open the pull down menu and select "Work/School Limitations/Excuse."

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta

Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
Received: / /
Patient Verification: Name: Garbo, Greta
Adm #: 1895752
Pat #: 7564552

Dictated: 02/20/97 13:31 Add More

Text 2 of 2

Category:

- Patient Identification and Statistics
- Diagnosis
- Referrals
- Counseling
- Prescriptions
- Work/School Limitations/Excuse
- Discharge
- Neuro Assessment

Exit No-Save
Clear User
Exit

Figure Chapter 3: -141: Work/School Limitations/Excuse (in Editor Add Mode)

(Image: editor-add-mode-6.bmp)

Entering/Modifying Work/School Limitations/Excuse Comments (manual) (cont.)

4b. Modify an existing Work/School Limitations/Excuse comment entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Work/School Limitations/Excuse.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 02

Dictator: Ross MD
 Received: / /
 Patient Verification: Name: Garbo, Greta
 Adm # 1895752
 Pat # 7564552

Dictated: 02/12/97 12:50
 Text 2 of 2

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add

Prior

Next

First

Last

Delete

Edit Header

Exit No-Save

Clear User

Exit

Figure Chapter 3: -142: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

6. Click the Exit button to save updated patient information.

Tips and Hints: Work/School Limitations/Excuse

- **The Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Work/School Limitations/Excuse comments text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Printing Prescriptions, Patient Instructions & Excuses

Printing Prescriptions

From the "Active Patient List" (your main tracking screen)

Medical Information

Prescriptions

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Prescriptions button in the INPUT section.
4. Double Click on one of the drugs initially listed (your customized drug listing).

Refer to "Writing Prescriptions (std. menu)," page 200, for expanded graphics.

Print

5. Click on the appropriate buttons to select prescription: No. (dosage), Type, route, Frequency, Duration. Note the check boxes: +1/2, As Needed, Refills PRN, Selection Permitted and Dispense As Written.
6. Click the Print button.

Printing Patient Instruction Sets

From the "Active Patient List" (your main tracking screen)

Medical Information

Patient Instructions

Add

or

Delete

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Patient Instructions button at the right of screen.
4. Select (click on) the appropriate instruction(s) from the instructions menu and click on the Add button to place the instruction(s) into the "Instructions to be printed" queue. To remove instruction(s) from the queue, select the instruction(s) and click on the Delete button.

Refer to "Queuing Patient Instruction Sets," page 207 for expanded graphics.

Print

5. Click on the Print button to print Patient Instructions

Printing a Work Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

A rectangular button with a textured background and the text "Medical Information" in a bold, sans-serif font.

2. Click the Medical Information button.

A rectangular button with a textured background and the text "Work Excuse" in a bold, sans-serif font.

3. Click on the Work Excuse button at the right of screen.

4. Click on check boxes and form fields to complete as appropriate.

Refer to "Writing a Work Excuse," page 208, for expanded graphics.

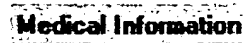
A rectangular button with a textured background and the text "Print" in a bold, sans-serif font.

5. Click on the Print button to print a Work Excuse.

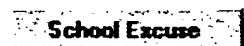
Printing a School Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

A rectangular button with a textured background and the text "Medical Information" in a bold, sans-serif font.

2. Click the Medical Information button.

A rectangular button with a textured background and the text "School Excuse" in a bold, sans-serif font.

3. Click on the School Excuse button at the right of screen.

4. Click on check boxes and form fields to complete as appropriate.

fer to "

A rectangular button with a textured background and the text "Print" in a bold, sans-serif font.

Writing a School Excuse," page 209, for expanded graphics.

5. Click on the Print button to print a School Excuse.

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Dictation Review and Modification

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

- 4a) Entering a new Dictation entry:

- Click on To Add button.
- Open the pull down menu and select a Category.

Editor - Add Mode Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Dictator: Ross MD
 Received: // Dictated: 02/20/97 13:31 Add More

Patient Verification
 Name: Garbo, Greta Text 2 of 2
 Adm #: 1895752
 Pat #: 7564552

Category:
 Patient Identification and Statistics
 Diagnosis
 Referrals
 Counseling
 Prescriptions
 Work/School Limitations/Excuse
 Discharge
 Neuro Assessment

Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -143: Adding Dictation (Editor Add Mode)

(Image: editor-add-mode-6.bmp)

Dictation Review and Modification (*continued*)

4b. Modify an existing Dictation entry:

Next
Prior

- Click on Next / Prior (or First / Last) buttons to locate Category.

- Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

Editor - View Mode Active User: J.E. Ross, MD

Patient Name: Greta Garbo

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed # 02

Dictator: Ross MD
 Received: // Dictated: 02/12/97 12:50
 Patient Verification: Name: Garbo, Greta Text 2 of 2
 Adm # 1895752
 Pat # 7564552

Use buttons to select category -->

Manually/Custom entered text will appear here

To Add
 Prior
 Next
 First
 Last
 Delete
 Edit Header

 Exit No-Save
 Clear User
 Exit

Figure Chapter 3: -144: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

Exit

- Click the Exit button to save updated patient information.

Transcription and Record Review/Approval

Medical Record Summary Review

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name: Garbo, Greta	Adm # 1895752	Pat # 7564552	SS # 450-81-9873	Bed G5a
<p>Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 121. Respiratory rate: 21.</p> <p>05/15/1997 13:40 Note recorded by J.E. Ross, MD Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 120. Respiratory rate: 21.</p> <p>09/18/1997 14:24 Note recorded by James Ross, Jr., MD</p> <p>09/18/1997 14:24 Note recorded by James Ross, Jr., MD Coma Scale: 14. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: confused. Best motor response: obeys commands. Systolic blood pressure: 135. Respiratory rate: 21. Mrs. Garbo is oriented to time, place and person. The patient is drowsy.</p> <p>09/18/1997 16:02 Note recorded by James Ross, Jr., MD Physician orders completed include: Apply silver sulfadiazine (Silvadene) to burn. Leave burn open. open.</p> <p>09/18/1997 17:11 Note recorded by James Ross, Jr., MD Physician orders completed include: Apply silver sulfadiazine (Silvadene) to burn.</p> <p>William L. Phillips, RN</p> <p>Kelly Townsend, RN</p> <p>James Ross, Jr., MD</p>				
Print		Apply Signature	Remove Signature	Clear User Exit

Figure Chapter 3: -145: Medical Record Summary

(Image: medical-record-summary-7.bmp)

4. Click the Scroll Bar to review information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Physician Medical Record Electronic Signatures

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section.
[brings you to the Medical Record Summary]

Medical Record Summary				Active User: James Ross, Jr., MD
Patient Name	Garbo, Greta			
Adm #	1895752	Pat #	7564552	SS # 450-81-9873 Bed G5a
<p>Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 121. Respiratory rate: 21.</p> <p>05/15/1997 13:40 Note recorded by J.E. Ross, MD Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 120. Respiratory rate: 21.</p> <p>09/18/1997 14:24 Note recorded by James Ross, Jr., MD</p> <p>09/18/1997 14:24 Note recorded by James Ross, Jr., MD Coma Scale: 14. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: confused. Best motor response: obeys commands. Systolic blood pressure: 135. Respiratory rate: 21. Mrs. Garbo is oriented to time, place and person. The patient is drowsy.</p> <p>09/18/1997 16:02 Note recorded by James Ross, Jr., MD Physician orders completed include: Apply silver sulfadiazine (Silvadene) to burn. Leave burn open. open.</p> <p>09/18/1997 17:11 Note recorded by James Ross, Jr., MD Physician orders completed include: Apply silver sulfadiazine (Silvadene) to burn.</p> <p>William L. Phillips, RN</p> <p>Kelly Townsend, RN</p> <p>James Ross, Jr., MD</p>				
Print		Apply Signature		Remove Signature
		Clear User		Exit

Figure Chapter 3: -146: Medical Record Summary

(Image: medical-record-summary-7.bmp)

Apply Signature
Remove Signature
Exit

4. Click on Apply or Remove Signature buttons as required.
5. Click the Exit button to return to the Medical Information screen.

TeleMed Transcript Locator

Use this utility to locate and correct transcripts sent with incorrect admission number or record component type.

Locating/Viewing/Correcting Transcript

From the "Active Patient List" (your main tracking screen)

Utilities

Transcript Locator

Find

1. Click the Utilities button.
2. Click on the Transcript Locator button at the right of screen.
3. Enter the Target Admission #
 - If you are not sure of the Admission #, click on the Communication Log button to locate it.
4. Click on the Find button.

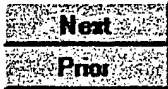
Mislocated Transcript Finder

Target Admission # **Find**

Dictator	Received	Dictated	Communications Log
Name	<input type="text"/>	<input type="text"/>	
Adm #	<input type="text"/>	<input type="text"/>	
Pat #	<input type="text"/>	<input type="text"/>	
<div style="border: 1px solid black; height: 200px; width: 100%;"></div>			Change
			Prior
			Next
			Exit

Figure Chapter 3: -147: Mislocated Transcript Finder

(Image: mislocated-transcript-finder.bmp)

Locating/Viewing/Correcting Transcript (continued)

5. Click on the Next / Prior button to locate the transcript component.
6. Correct admission number or record component type as appropriate.



7. Click on the Change button.

Tips and Hints: Transcript Locator

- Each block is designated to appear in a separate component of the medical record as noted by the pull down field.
- If the Adm. No. was in error, the number must be changed on each block, and Change selected to save the change.
- Any element displayed in yellow can be changed.
- Note: the primary function of this utility is to locate transcriptions which did not attach to the appropriate medical record. The system uses the admission number as the link. If the admission number is not correct when sent from the dictation company or department, the system will not attach the blocks to the proper medical record. The other elements can be easily edited through the Transcript Editor button on the Medical Information screen.

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TeleMed Progress Notes Section

Vital Signs

Entering Vital Signs (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Vital Signs

3. Click on the Vital Signs button in the INPUT section.

Vital Signs Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

Nurse: James Ross, Jr., MD
 Date: 09/30/97 Time: 13:29

Patient is pregnant: Allergies: Damerol, sulfa
 Reglan Tetanus expired

Orthostatic Vital Signs

	Pulse	B/P
Reclining		/
Sitting		/
Standing		/

Time: 13:29
☐ Physician Notified

B/P / **Pulse** **Resp** **Temperature** ☐ Oral ☐ Rectal
☐ Tympanic ☐ Axillary

O2 Saturation % ☐ ☐ See Rhythm Strip For Frequent Vital Signs and Rhythm Disturbances

Bedside Glucose **Arterial B/P** **Arterial Mean** **CVP (Average)**
 /

Fetal Heart Rate **Pulmonary Wedge Pressure**

Height 5 Ft 6 Inches
Weight 129 Lbs 59 Kg
 Enter weight in Lbs or Kg
☐ Weight Stated by Patient
☒ Patient Weighed

☐ Physician Notified

Exit No-Save
Clear User
Exit

Figure Chapter 3: -148: Vital Signs

(Image: vital-signs.bmp)

4. Click on check boxes and form fields to complete as appropriate.

Exit

5. Click the Exit button to return to the Medical Information screen.

Viewing Vital Signs

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Vital Signs

3. Click on the Vital Signs button in the HISTORICAL section.

Vital Signs Report Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

Date	09/08/96	05/15/97	05/15/97	05/15/97	05/15/97	05/15/97	05/15/97
Time	10:01	11:52	12:26	12:53	13:35	13:39	13:40
Pulse	98						
Respiration	24	21	21	21	21	21	21
BP	124/66	125/90	125/90	120/95	120/90	121/90	120/90
Temperature	99.5 (0)						
O2 Saturation	96						
Bedside Glucose	121						
Pulse Reclining							
Pulse Sitting							
Pulse Standing							
BP Reclining							
BP Sitting							
BP Standing							
Arterial BP							
Arterial Mean							
Pulmonary Wedge							
Fetal Heart							

Figure Chapter 3: -149: Vital Signs Report

(Image: vital-signs-report.bmp)

Exit

7. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Vital Signs

- You can review the Vital Signs record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Assessments

Entering Neurological Assessment (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Assessment Neuro

4. Click on the Assessment Neuro button.

Assessment - Neuro Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta SS #: 450-81-9873

Adm #: 1895752 Pat #: 7564552 Bed: 07A

Directed To <input type="checkbox"/> Yes <input type="checkbox"/> No Time <input type="checkbox"/> Yes <input type="checkbox"/> No Place <input type="checkbox"/> Yes <input type="checkbox"/> No Person		Arousal <input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Stuporous <input type="checkbox"/> Comatose <input type="checkbox"/> Decorticate <input type="checkbox"/> Decerebrate		Pupils <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> L <input type="checkbox"/> R Normally Reactive <input type="checkbox"/> L <input type="checkbox"/> R Sluggishly Reactive <input type="checkbox"/> L <input type="checkbox"/> R Fixed <input type="checkbox"/> L <input type="checkbox"/> R Dilated <input type="checkbox"/> L <input type="checkbox"/> R Pinpoint		Pupil Size <input type="checkbox"/> 1 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 2 mm <input type="checkbox"/> 7 mm <input type="checkbox"/> 3 mm <input type="checkbox"/> 8 mm <input type="checkbox"/> 4 mm <input type="checkbox"/> 9 mm <input type="checkbox"/> 5 mm <input type="checkbox"/> 10 mm		Time: 13:33 <input type="checkbox"/> Physician Notified Phy. Exam Physical ABC Neuro. Assess Trauma Adult Trauma <1 Trauma 1-2 Trauma 2-5 Trauma 5-15 Exit No-Save Clear User Exit			
Speech <input type="checkbox"/> Normal <input type="checkbox"/> Understands What Is Said <input type="checkbox"/> Doesn't Understand What Is Said <input type="checkbox"/> Slurred, Normal Sentences		<input type="checkbox"/> Slurred, Unintelligible <input type="checkbox"/> Uses Wrong Words <input type="checkbox"/> Unable To Speak		Cranial Nerve Function <input type="checkbox"/> L <input type="checkbox"/> R Normal <input type="checkbox"/> L <input type="checkbox"/> R Facial Droop <input type="checkbox"/> L <input type="checkbox"/> R Lid Droop <input type="checkbox"/> L <input type="checkbox"/> R Facial Sensory Deficit							
Motor Function Normal Strength Lifts & Holds Lifts & Falls Back Moves On Bed No Movement		Arm Lt <input type="checkbox"/>	Leg Lt <input type="checkbox"/>	Arm Rt <input type="checkbox"/>	Leg Rt <input type="checkbox"/>	Sensory Function Normal To Pinprick Normal To Soft Touch Subjective Deficit Hypesthesia Anesthesia		Arm Lt <input type="checkbox"/>	Leg Lt <input type="checkbox"/>	Arm Rt <input type="checkbox"/>	Leg Rt <input type="checkbox"/>
Additional Notes <div style="border: 1px solid black; height: 40px; width: 100%;"></div>											

Figure Chapter 3: -150: Assessment - Neuro

(Image: assessment-neuro.bmp)

5. Enter (click on) all appropriate neurological conditions.
6. Click the Exit button to return to the Medical Information screen.

Exit

Tips and Hints: Neurological Assessment

- You can review the Neurological Assessment record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
 - Assessment Physical - ABC
 - Nursing Physical Exam
 - All Truama screens

Entering Physical Exam (std. menu)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Physical Exam

4. Click on the (Nursing) Physical Exam button.

Nursing Physical Exam Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

<p>Cardiac Status</p> <p><input type="checkbox"/> Normal Sinus Rhythm</p> <p><input type="checkbox"/> Tachycardia</p> <p><input type="checkbox"/> Bradycardia</p> <p><input type="checkbox"/> No Audible Heart Tones</p> <p><input type="checkbox"/> Asystole</p> <p><input type="checkbox"/> Atrial Fibrillation</p> <p><input type="checkbox"/> Ventricular Fibrillation</p> <p><input type="checkbox"/> Pacemaker Rhythm</p> <p><input type="checkbox"/> Pacer Spikes, No Capture</p> <p>Abdomen</p> <p><input type="checkbox"/> Tender <input type="checkbox"/> LUQ <input type="checkbox"/> RUQ</p> <p><input type="checkbox"/> Generalized <input type="checkbox"/> LLQ <input type="checkbox"/> RLQ</p> <p><input type="checkbox"/> Non-Tender <input type="checkbox"/> Distended</p> <p><input type="checkbox"/> Rigid <input type="checkbox"/> No Distention</p> <p>Bowel Sounds</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Hyperactive</p> <p><input type="checkbox"/> Hypoactive</p> <p><input type="checkbox"/> Absent</p> <p>Additional Notes</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<p>General Appearance</p> <p><input type="checkbox"/> NAD <input type="checkbox"/> Mild Distress <input type="checkbox"/> Unable to Lie Still</p> <p><input type="checkbox"/> Smiling <input type="checkbox"/> In Severe Pain <input type="checkbox"/> In Extremis</p> <p><input type="checkbox"/> Diaphoretic <input type="checkbox"/> In Full Arrest</p> <p>Pulses</p> <p>Radial</p> <p>L <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent <input type="checkbox"/> Bounding</p> <p>R <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent <input type="checkbox"/> Bounding</p> <p>Tibial</p> <p>L <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent <input type="checkbox"/> Bounding</p> <p>R <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent <input type="checkbox"/> Bounding</p> <p>Pedal</p> <p>L <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent <input type="checkbox"/> Bounding</p> <p>R <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent <input type="checkbox"/> Bounding</p>	<p>Time 13:33</p> <p><input type="checkbox"/> Physician Notified</p> <p>Phy. Exam</p> <p>Physical ABC</p> <p>Neuro. Assess</p> <p>Trauma Adult</p> <p>Trauma < 1</p> <p>Trauma 1-2</p> <p>Trauma 2-5</p> <p>Trauma 5-15</p> <p>Exit No-Save</p> <p>Clear User</p> <p>Exit</p>
--	--	---

Figure Chapter 3: -151: Nursing Physical Exam

(Image: nursing-physical-exam.bmp)

5. Enter (click on) all appropriate physical conditions.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Physical Exam

- You can review the Physical Exam record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
 - Assessment Physical - ABC
 - Assessment - Neuro
 - All Truama screens

Entering Physical ABC (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Assessment ABC

4. Click on the Assessment ABC button.

Assessment Physical - ABC Active User James Ross, Jr., MD

Patient Name Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

Airway Retractions <input type="checkbox"/> None <input type="checkbox"/> Intercostal <input type="checkbox"/> Subcostal <input type="checkbox"/> Suprasternal Notch	Respiratory Status <input type="checkbox"/> Normal <input type="checkbox"/> Shallow <input type="checkbox"/> Labored <input type="checkbox"/> Grunting <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Tachypneic <input type="checkbox"/> Hyperventilating <input type="checkbox"/> Hypoventilating <input type="checkbox"/> In Respiratory Arrest	Verbalizations <input type="checkbox"/> Clear <input type="checkbox"/> Hoarse <input type="checkbox"/> Muffled <input type="checkbox"/> Drooling <input type="checkbox"/> None
Breathing Sounds <input type="checkbox"/> L <input type="checkbox"/> R Clear <input type="checkbox"/> L <input type="checkbox"/> R Rales (Crackles) <input type="checkbox"/> L <input type="checkbox"/> R Wheezes <input type="checkbox"/> L <input type="checkbox"/> R Pleural Rub <input type="checkbox"/> L <input type="checkbox"/> R Rhonchi <input type="checkbox"/> L <input type="checkbox"/> R Tubular <input type="checkbox"/> L <input type="checkbox"/> R Decreased <input type="checkbox"/> L <input type="checkbox"/> R Absent	Depth <input type="checkbox"/> Full <input type="checkbox"/> Shallow <input type="checkbox"/> Splinting <input type="checkbox"/> Not Breathing	Breathing Position <input type="checkbox"/> Normal <input type="checkbox"/> Upright <input type="checkbox"/> Sniffing <input type="checkbox"/> Chest Forward (Increased AP Diameter)
Circulation Skin Moisture <input type="checkbox"/> Normal <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic	Skin Temp. <input type="checkbox"/> Normal <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Cold	Skin Color <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Mottled <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Ashen
Capillary Refill <input type="checkbox"/> Normal <input type="checkbox"/> Delayed <input type="checkbox"/> Refill Time < 2 Sec. <input type="checkbox"/> Refill Time > 2 Sec.		

Time 13:33

☐ Physician Notified

Phy. Exam

Physical ABC

Neuro. Assess

Trauma Adult

Trauma < 1

Trauma 1-2

Trauma 2-5

Trauma 5-15

Exit No-Save

Clear User

Exit

Figure Chapter 3: -152: Assessment Physical - ABC

(Image: assessment-physical-abc.bmp)

5. Enter (click on) all appropriate physical ABC conditions.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Physical ABC

- You can review the Physical ABC record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
 - Nursing Physical Exam
 - Assessment - Neuro
 - All Truama screens

Entering Trauma Score (std. menu)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Assessment Trauma

4. Click on the Assessment Trauma button.

Trauma Score - Adult Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta Time: 13:33

Adm #: 1895752 Pat #: 7564552

SS #: 450-81-9873 Bed: 07A

Glasgow Coma Scale		Score Survivors	
Eye Opening <input type="checkbox"/> Spontaneously (4) <input type="checkbox"/> To Speech (3) <input type="checkbox"/> To Pain (2) <input type="checkbox"/> None (1) <input type="checkbox"/> Closed By Swelling		B/P	/
Best Verbal Response <input type="checkbox"/> Alert and Oriented (5) <input type="checkbox"/> Confused (4) <input type="checkbox"/> Inappropriate (3) <input type="checkbox"/> Incomprehensible (2) <input type="checkbox"/> None (1) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Endo Tube or Trach		Resp	
Best Motor Response (Use Best Arm) <input type="checkbox"/> Obey Commands (6) <input type="checkbox"/> Removes Pain Stim (5) <input type="checkbox"/> Localizes Pain (4) <input type="checkbox"/> Flexion To Pain (3) <input type="checkbox"/> Extension To Pain (2) <input type="checkbox"/> None (1)		Revised Trauma Score	
		Oriented To	Arousal
		Time <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alert
		Place <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Drowsy
		Person <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lethargic
			<input type="checkbox"/> Stuporous
			<input type="checkbox"/> Comatose

☐ Physician Notified

Figure Chapter 3: -153: Trauma Score (adult)

(Image: trauma-score-adult.bmp)

5. Enter (click on) all appropriate trauma conditions for the appropriate age groups (i.e. Trauma; <1, 1-2, 2-5, 5-15, and Adult).

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Trauma Score

- You can review the Trauma Score record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
 - Nursing Physical Exam
 - Assessment - Neuro
 - Assessment Physical -ABC
 - All Truama screens

Medication Orders/Therapeutic Orders

Entering Medication Orders/Therapeutic Orders (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Progress Notes Active User: James Ross, Jr., MD

Patient Name: Garbo, Grata Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

Patient is pregnant. Allergies: Demerol, sulfa, Reglan. Tetanus expired.

Time: 13:05

Order Completed

☐ Physician Notified

Assessment Neuro	Elimination	Move/Admit	Status
Assessment ABC	Emotional	Nausea	Vitals
Assessment Trauma	Gastric	Patient Care	Wound
Diet	In/Out	Physical Exam	
Discharge	IV	Protective Measures	
Drainage	Mobility	Splint	

Additional Notes

Figure Chapter 3: -154: Progress Notes

(Image: progress-notes.bmp)

5. Click on menu and form fields and complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Orders

- You can review the Progress Notes record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Entering IV (std. menu)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

IV

4. Click on the IV button.

IV Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed: 07A

Patient is pregnant Allergies: Demerol, sulfa, Reglan Tetanus expired Time 13:33

<input type="checkbox"/> Running Normally at <input type="text"/> cc/hr <input type="checkbox"/> Site Is Infiltrated <input type="checkbox"/> New IV Site Established <input type="checkbox"/> IV Discontinued w/Catheter Intact <input type="checkbox"/> Has Received <input type="text"/> cc's Total <input type="checkbox"/> No Adverse Reaction Noted	Catheter Site <input type="checkbox"/> L <input type="checkbox"/> R Hand <input type="checkbox"/> L <input type="checkbox"/> R Wrist <input type="checkbox"/> L <input type="checkbox"/> R Forearm <input type="checkbox"/> L <input type="checkbox"/> R Scalp <input type="checkbox"/> L <input type="checkbox"/> R AC Fossa <input type="checkbox"/> L <input type="checkbox"/> R Foot Prep for IV <input type="checkbox"/> Alcohol <input type="checkbox"/> Betadine	Catheter Size <input type="checkbox"/> 25 Gauge <input type="checkbox"/> 24 Gauge <input type="checkbox"/> 23 Gauge <input type="checkbox"/> 22 Gauge <input type="checkbox"/> 20 Gauge <input type="checkbox"/> 18 Gauge <input type="checkbox"/> 16 Gauge <input type="checkbox"/> 14 Gauge <input type="checkbox"/> Butterfly <input type="checkbox"/> PICC Line	Dressing <input type="checkbox"/> Gauze <input type="checkbox"/> Polyethylene <input type="checkbox"/> Tape Ointment <input type="checkbox"/> Betadine (Povidone-Iodine) <input type="checkbox"/> Neosporin (Triple Antibiotic) <input type="checkbox"/> Polysporin (Polymixin, Bacitracin) <input type="checkbox"/> Bacitracin
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☐ Physician Notified

I/O

Additional Notes

Figure Chapter 3: -155: IV

(Image: iv.bmp)

5. Click on check boxes and form fields to complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: IV

- You can review the IV record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
 - Intake/Output
 - Gastric/Suction
 - Elimination
 - Drainage/Nausea/Vomiting

Wound/Splint Management

Entering Wound Management (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Vital Signs

3. Click on the Progress Notes button in the INPUT section.

Wound

4. Click on the Wound button.

Wound Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta
Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 07A

Patient is pregnant. Allergies: Demerol, sulfa, Reglan. Tetanus expired.

Site Cleaned With	Ointment Applied	Dressing Applied	Patient Instructions
<input type="checkbox"/> Hydrogen Peroxide	<input type="checkbox"/> Neosporin (Triple Antibiotic)	<input type="checkbox"/> Bandaid	<input type="checkbox"/> Wound Dress.
<input type="checkbox"/> Betadine Solution (Povidone-Iodine)	<input type="checkbox"/> Polysporin	<input type="checkbox"/> Plain Gauze Dressing	<input type="checkbox"/> Wound Infec.
<input type="checkbox"/> Hibiclens (Chlorhexidine Gluconate)	<input type="checkbox"/> Bacitracin	<input type="checkbox"/> Ace Wrap	<input type="checkbox"/> Punct. Wound
<input type="checkbox"/> Normal Saline	<input type="checkbox"/> Gentamycin	<input type="checkbox"/> Adaptic, Plain Gauze Dressing	<input type="checkbox"/> Animal Bite
	<input type="checkbox"/> Betadine	<input type="checkbox"/> Zeroform, Plain Gauze Dressing	<input type="checkbox"/> Human Bite
		<input type="checkbox"/> Telfa, Plain Gauze Dressing	<input type="checkbox"/> Use Antibiotic Ointment
		<input type="checkbox"/> Tubegauze Dressing	<input type="checkbox"/> Lac. Face
		<input type="checkbox"/> Steri Strips	<input type="checkbox"/> Lac. Foot
		<input type="checkbox"/> Eye Patch <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	<input type="checkbox"/> Lac. Hand
			<input type="checkbox"/> Lac. Knee
			<input type="checkbox"/> Lac. Tendon
			<input type="checkbox"/> Lac. Nonsuture
			<input type="checkbox"/> Lac. Suture
			<input type="checkbox"/> Oral Nonsuture
			<input type="checkbox"/> Oral Suture
			<input type="checkbox"/> Absorb Sutures

Suture Removal

☐ Sutures Removed

☐ Staples Removed

☐ No Significant Bleeding

☐ Significant Bleeding Controlled

☐ Procedure Tolerated Well

Wound

☐ Cleaned, Dressed

☐ Pressure Dressing

☐ Pressure to Wound

☐ Wound Care/Dressing Change Done

Appearance

☐ Normal

☐ Bleeding

☐ Clean Edged

☐ Clotted/Scabbed

☐ Exudative

☐ Jagged

☐ Macerated

☐ Red/Inflamed

☐ Swollen

☐ Wound Separated

Additional Notes

Figure Chapter 3: -156: Wound

(Image: wound.bmp)

5. Click on check boxes and form fields to complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Entering Splint Management (std. menu)*From the "Active Patient List" (your main tracking screen)*

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Vital Signs

3. Click on the Progress Notes button in the INPUT section.

Splint

4. Click on the Splint button.

Splint Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

Patient is pregnant. Allergies: Demerol, sulfa, Reglan. Tetanus expired

Time: 13:33
☐ Physician Notified

<input type="checkbox"/> Ace Wrap Applied	<input type="checkbox"/> C-Collar Applied
<input type="checkbox"/> Slng Applied	<input type="checkbox"/> Velcro Wrist Splint Left
<input type="checkbox"/> Buddy Tape	<input type="checkbox"/> Velcro Wrist Splint Right
<input type="checkbox"/> Splint Applied, Checked	<input type="checkbox"/> Knee Immobilizer Left
<input type="checkbox"/> Cast Applied, Checked	<input type="checkbox"/> Knee Immobilizer Right
	<input type="checkbox"/> Air Cushion Ankle Splint Left
	<input type="checkbox"/> Air Cushion Ankle Splint Right

Additional Notes

Figure Chapter 3: -157: Splint

(Image: splint.bmp)

5. Click on check boxes and form fields to complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Wound and Splint

- You can review the Wound and Splint record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Patient Status Documentation

Patient Status Entry (std. menu) - Status

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Status

4. Click on the Status button.

Status 1 Active User: J.E. Ross, MD

Patient Name: Garbo, Greta
 Adm #: 1895752 Pat #: 7564552 SS #: 450-81-9873 Bed: 02

Patient is pregnant Allergies: Demerol, sulfa Tetanus expired

Pain <input type="checkbox"/> Complaints of Increasing <input type="checkbox"/> Complaints of Severe Pain <input type="checkbox"/> Pain Is Rated By Patient As _____ Scale of 1-10 <input type="checkbox"/> Pain Is _____ % improved <input type="checkbox"/> Feels "Better" <input type="checkbox"/> Mild <input type="checkbox"/> Feels "Worse" <input type="checkbox"/> Moderate <input type="checkbox"/> Pain "Worse" w/Movement <input type="checkbox"/> Severe <input type="checkbox"/> Pain Completely Better <input type="checkbox"/> Medication Gave Relief <input type="checkbox"/> Medication Did Not Help	Status <input type="checkbox"/> Family at Bedside <input type="checkbox"/> Family Requested to Stay <input type="checkbox"/> Patient Not In Room <input type="checkbox"/> Turned <input type="checkbox"/> Uncomfortable, Turned <input type="checkbox"/> Comfortable <input type="checkbox"/> Asleep <input type="checkbox"/> Fetal Position	<input type="checkbox"/> Translator Used <input type="checkbox"/> Patient Ready for Doctor Examination <input type="checkbox"/> DNR <input type="checkbox"/> Doctor at Bedside <input type="checkbox"/> Treatment Discussed w/Doctor <input type="checkbox"/> Care Discussed w/Nurse	<input type="checkbox"/> Physician Notified <input type="button" value="Edit Notes"/> <input type="button" value="Vital Signs"/> <input type="button" value="Neuro Assmt"/> <input type="button" value="Nursing PE"/> <input type="button" value="Orders"/> <input type="button" value="Wound/Splint"/> <input type="button" value="Status 1"/> <input type="button" value="Status 2"/> <input type="button" value="Move/Admit"/> <input type="button" value="Disposition"/> <input type="button" value="Exit No-Save"/> <input type="button" value="Clear User"/> <input type="button" value="Exit"/>
Feels <input type="checkbox"/> Faint <input type="checkbox"/> Dizzy <input type="checkbox"/> Weak <input type="checkbox"/> Anxious	Shortness of Breath <input type="checkbox"/> Increased <input type="checkbox"/> Mild <input type="checkbox"/> Improved <input type="checkbox"/> Moderate <input type="checkbox"/> No Respiratory Distress <input type="checkbox"/> Severe	Mobility <input type="checkbox"/> Out of Bed w/Assistance <input type="checkbox"/> Out of Bed wo/Assistance <input type="checkbox"/> Up Using Cane <input type="checkbox"/> Up Using Crutches <input type="checkbox"/> Up Using Walker <input type="checkbox"/> Up In Wheelchair	

O2 Saturation _____ % On O2 _____ % _____ L/Min

Additional Notes

Figure Chapter 3: -158: Status

(Image: status.bmp)

5. Click on check boxes and form fields to complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

utput (I&O)

Admission

Patient List" (your main tracking screen)

- 1. Select a patient from the "Grease Board" (list menu).
- 2. Click the Medical Information button.
- 3. Click on the Admission button at the right of screen.
- 4. Click on the "Patient Status" pull down menu.

Active User: J.E. Ross, MD

Patient # 16548 SS # Bed: Unknown

☐ VIP Arrived At ED

Date 12/09/1996 Time 09:12 A

Mode of Arrival

☐ Ambulatory

☐ Wheelchair

☐ Carried

☐ Ambulance

☐ EMS

☒ Unselected

☐ Female ☒ Unselected

Marital

☐ Single

☐ Married

☐ Divorced

☐ Widow(er)

☐ Unselected

Patient Type

☒ Emergency

☐ Inpatient

☐ Outpatient

☐ Unselected

on To Select

Patient Status

Financial Class

Accident

☐ Yes

☐ Job Related

Accident Date

Emergency Complete

Inpatient Preadmit

Inpatient Active

Inpatient Discharged

Inpatient Complete

Outpatient Temporary

Outpatient Active

3: -170: Admission (Patient Status)

- 5. Click on check boxes and form fields to complete as appropriate.
- 6. Click the Exit button to return to the Medical Information screen.

Entering Patient Output

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Discharge

3. Click on the Discharge button at the right of screen.

Discharge Active User: J.E. Ross, MD

Patient Name: Smith, Admitted: B107378119 Pat #: B107378119 SS #: Bed: Unknown

Released From ED By: A

Discharge Condition

☐ Good ☐ Improved

☐ Fair ☐ Stable

☐ Poor ☐ Unstable

Patient Expired

☐ Patient Expired

Date:

Time:

Released From ED

Date: A

Time:

☐ Discharged

☐ Transferred

☐ Managed Care Denial

☐ Left Without Being Registered

☐ Left Without Seeing Physician

☐ Left Before Receiving Instructions

☐ Refused Admission

☐ Left Against Medical Advice

Admit To Hospital

☐ Admitted to Hospital ☐ Admitted to ICU

☐ Admitted 23 Hr Obs ☐ Sent to Outpatient/OR

☐ Admitted to Maternity Unit

Admission Date:

Admission Time:

Admitted To Doctor:

ED Physician:

Assign ED Physician:

☐ Bed Was Used

☒ Active Patient

☐ Inactive Patient - Hold To Complete Record

☐ Hold Room For Cleaning

☐ Inactive Patient (Removes From Listing)

Admission

Social History

Guarantor

Insurance

Employer/Contact

Exit No-Save

Clear User

Exit

Figure Chapter 3: -171: Discharge

(Image: discharge.bmp)

5. Click on check boxes and form fields to complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Patient Input & Output (I&O)

- *Alternate access to these screens:*
 - Admission
 - Discharge
 - Employer/Contact
 - Guarantor
 - Insurance
 - Social History

Editing Progress Notes

Modify Progress Notes (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Edit Notes

4. Click on the Edit Notes button and enter password at prompt.

Progress Notes Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta
 Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed 07A

Time: 16:02

EDIT MODE

Order Completed ☐ Physician Notified

Apply silver sulfadiazine (Silvadene) to burn. Leave burn open.

Edit Notes

Assessment Neuro	Elimination	Move/Admit	Status
Assessment ABC	Emotional	Nausea	Vitals
Assessment Trauma	Gastric	Patient Care	Wound
Diet	In/Out	Physical Exam	
Discharge	IV	Protective Measures	
Drainage	Mobility	Splint	

Additional Notes

Exit No-Save

Clear User

Exit

Figure Chapter 3: -172: Progress Notes - Edit

(Image: progress-notes-edit-mode.bmp)

5. Click on the multiline form field to manually add or modify any text.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Progress Notes

- You can review the Progress record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Progress Notes Review

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Prog. Notes Summary

3. Click on the Progress Notes Summary button in the HISTORICAL section.

Progress Record Summary Active User: James Ross, Jr., MD

Patient Name: Garbo, Greta

Adm # 1895752 Pat # 7564552 SS # 450-81-9873 Bed G5a

Progress

Vitals

Date	Time	Pulse	Resp	BP	Temp	O2Sat	Bglu	Recorded By
09/08/96	10:01	98	24	124/66	99.5 (O)	96	121	Kelly Townsend, RN
05/15/97	11:52		21	125/90				J.E. Ross, MD
05/15/97	12:26		21	125/90				J.E. Ross, MD
05/15/97	12:53		21	120/95				J.E. Ross, MD
05/15/97	13:35		21	120/90				J.E. Ross, MD
05/15/97	13:39		21	121/90				J.E. Ross, MD
05/15/97	13:40		21	120/90				J.E. Ross, MD
05/15/97	13:48	88	21	125/90	98.3 (T)			J.E. Ross, MD
09/18/97	14:24		21	135/90				James Ross, Jr., MD

Notes

05/12/97 12:29 Note recorded by J.E. Ross, MD
Coma Scale: 11. Eyes open with painful stimuli. Best verbal response: inappropriate. Best motor response: obeys commands. Size: greater than 20 kg (44 lb).

05/15/97 11:52 Note recorded by J.E. Ross, MD
Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 125. Respiratory rate: 21. She is oriented to time, place and person.

05/15/97 12:26 Note recorded by J.E. Ross, MD
Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 125. Respiratory rate: 21.

Print Apply Signature Remove Signature Clear User Exit

Figure Chapter 3: -173: Progress Record Summary

(Image: progress-record-summary.bmp)

Exit

4. Click the Exit button to return to the Medical Information screen.

Nurse Notes Electronic Signatures

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Prog. Notes Summary

3. Click on the Progress Notes Summary or Summary buttons in the HISTORICAL section.

Progress Record Summary								Active User: James Ross, Jr., MD																																																																																																					
Patient Name: Garbo, Greta																																																																																																													
Adm #: 1895752		Pat #: 7564552		SS #: 450-81-9873		Bed G5a																																																																																																							
<p>Progress</p> <p><i>Vitals</i></p> <table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Pulse</th> <th>Resp</th> <th>BP</th> <th>Temp</th> <th>O2Sat</th> <th>Bglu</th> <th colspan="2">Recorded By</th> </tr> </thead> <tbody> <tr> <td>09/08/96</td> <td>10:01</td> <td>98</td> <td>24</td> <td>124/66</td> <td>99.5 (O)</td> <td>96</td> <td>121</td> <td colspan="2">Kelly Townsend, RN</td> </tr> <tr> <td>05/15/97</td> <td>11:52</td> <td></td> <td>21</td> <td>125/90</td> <td></td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>05/15/97</td> <td>12:26</td> <td></td> <td>21</td> <td>125/90</td> <td></td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>05/15/97</td> <td>12:53</td> <td></td> <td>21</td> <td>120/95</td> <td></td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>05/15/97</td> <td>13:35</td> <td></td> <td>21</td> <td>120/90</td> <td></td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>05/15/97</td> <td>13:39</td> <td></td> <td>21</td> <td>121/90</td> <td></td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>05/15/97</td> <td>13:40</td> <td></td> <td>21</td> <td>120/90</td> <td></td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>05/15/97</td> <td>13:48</td> <td>88</td> <td>21</td> <td>125/90</td> <td>98.3 (T)</td> <td></td> <td></td> <td colspan="2">J.E. Ross, MD</td> </tr> <tr> <td>09/18/97</td> <td>14:24</td> <td></td> <td>21</td> <td>135/90</td> <td></td> <td></td> <td></td> <td colspan="2">James Ross, Jr., MD</td> </tr> </tbody> </table> <p><i>Notes</i></p> <p>05/12/97 12:29 Note recorded by J.E. Ross, MD Coma Scale: 11. Eyes open with painful stimuli. Best verbal response: inappropriate. Best motor response: obeys commands. Size: greater than 20 kg (44 lb).</p> <p>05/15/97 11:52 Note recorded by J.E. Ross, MD Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 125. Respiratory rate: 21. She is oriented to time, place and person.</p> <p>05/15/97 12:26 Note recorded by J.E. Ross, MD Coma Scale: 15. Revised Trauma Score: 8. Eyes open spontaneously. Best verbal response: oriented. Best motor response: obeys commands. Systolic blood pressure: 125. Respiratory rate: 21.</p>										Date	Time	Pulse	Resp	BP	Temp	O2Sat	Bglu	Recorded By		09/08/96	10:01	98	24	124/66	99.5 (O)	96	121	Kelly Townsend, RN		05/15/97	11:52		21	125/90				J.E. Ross, MD		05/15/97	12:26		21	125/90				J.E. Ross, MD		05/15/97	12:53		21	120/95				J.E. Ross, MD		05/15/97	13:35		21	120/90				J.E. Ross, MD		05/15/97	13:39		21	121/90				J.E. Ross, MD		05/15/97	13:40		21	120/90				J.E. Ross, MD		05/15/97	13:48	88	21	125/90	98.3 (T)			J.E. Ross, MD		09/18/97	14:24		21	135/90				James Ross, Jr., MD	
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Print		Apply Signature		Remove Signature		Clear User		Exit																																																																																																					

Figure Chapter 3: -174: Progress Record Summary

(Image: progress-record-summary.bmp)

Apply Signature
Remove Signature
Exit

4. Click on Apply or Remove Signature buttons as required.

5. Click the Exit button to return to the Medical Information screen.

TeleMed Department Clerks Section

Status Updates (X-Ray, Orders, Labs and Tests)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu)

Medical Information

2. Click the Medical Information button.

Department Clerk

3. Click on the Department Clerk button at the right of screen.

Department Clerk Active User: J.E. Ross, MD

Patient Name: Byrd, Fickle
 Adm #: G16534459 Pat #: 16548 SS #: Bed: Unknown

Patient Status NNNN		STATUS	Reset Status
X-Rays Ordered	X-Rays Received	Lower Case-Ordered	X-Rays Not Ordered
Orders Made	Orders Completed	Capital-Back	Orders Not Made
Labs Ordered	Lab Results Received	X = X-Rays	Labs Not Ordered
Tests Ordered	Tests Results Received	O = Orders	Tests Not Ordered
		L = Labs	
		T = Tests	
		N = Not Ordered	

Exit No-Save

Clear User

Exit

Figure Chapter 3: -175: Department Clerk

(Image: department-clerk.bmp)

4. Click the appropriate status button(s) for X-Ray, Orders, Labs and Tests as ordered received or reset as required.

Exit

5. Click the Exit button to return to the Medical Information screen.

TeleMed Emergency Department Logs and Reports

Logs and Reports

Accessing the Reports Generator

From the "Active Patient List" (your main tracking screen)

Utilities

1. Click the Utilities button.

Reports

2. Click on the Reports button at the left of screen.

Reports Active User: James Ross, Jr., MD

Time Range

- ☐ All (WARNING: Large Quantity Of Pages)
- ☐ Previous Day (24 Hours)
- ☐ Current Day To Current Time
- ☐ Previous Month
- ☐ Current Month To Current Time
- ☐ Specified Period
 - Date From:
 - Date To:

Visit Reports

- ☐ New Visit Log
- ☐ Visit Status Log
- ☐ Completed Visit Log
- ☐ Admitted Log
- ☐ Patient Statistics

Specialty Reports

- ☐ Greater Than 6 Hours
- ☐ Seen Again Within 72 Hours
- ☐ Emergency Department Statistics
- ☐ Mortality

Transcript Reports

- ☐ Transcript Log
- ☐ Medical Records Without Transcripts
- ☐ Medical Records Waiting For Transcripts
- ☐ Medical Records Transcript Status

Daily Report Group

Print

Exit

Figure Chapter 3: -176: Reports (Generator)

(Image: reports.bmp)

4. Select the Time Range settings for your report.

Printing Visit Reports

Continued from Accessing the Reports Generator, Page 264.

5. Select any combination of reports under "Visit Reports" at upper center of screen (New Visit Log, Visit Status Log and/or Completed Visit Log).



6. Click on the Print button at the right of screen.

Tips and Hints: Visit Reports

- New Visit Log provides a listing of the following visit information for selected period of time:
 - Patient #, Admission #, Arrival Date/Time, Patient Name, Sex, ED Physician
- New Visit Log provides the following summary information for selected period of time:
 - # Total Visits
 - # Visits Using Beds,
 - % Visits Using Beds
- ◊ Visit Status Log provides a listing of the following visit information for selected period of time:
 - Visit Date/Time, Admission #, Patient Name, Exit Status
- ◆ Completed Visit Log provides a listing of the following visit information for selected period of time:
 - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By
- ◆ Completed Visit Log provides the following summary information for selected period of time:

<ul style="list-style-type: none"> - # Expired - # Released - # Transferred - # Left - Managed Care Denial - # Left W/O Being Registered - # Left W/O Seeing Physician - # Left Before Receiving Instructions - # Refused Admission 	<ul style="list-style-type: none"> - # Left Against Medical Advice - # Admitted To Hospital - # Admitted 23 Hr Observation - # Admitted ICU - # Sent To Outpatient - # Admitted To Maternity - # Total Patients
---	--

Specialty Reports

Printing Specialty Reports

Continued from Accessing the Reports Generator, Page 264.

5. Select any combination of reports under "Specialty Reports" at lower left of screen (Greater Than 6 Hours, Seen Again Within 72 Hours, Emergency Department Statistics, Mortality).



6. Click on the Print button at the right of screen.

Tips and Hints: Specialty Reports

- **Greater Than 6 Hours & Seen Again Within 72 Hours** provides a listing of the following visit information for selected period of time:
 - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By
- **Greater Than 6 Hours & Seen Again Within 72 Hours** provides the following summary information for selected period of time:

<ul style="list-style-type: none"> - # Expired - # Released - # Transferred - # Left - Managed Care Denial - # Left W/O Being Registered - # Left W/O Seeing Physician - # Left Before Receiving Instructions - # Refused Admission 	<ul style="list-style-type: none"> - # Left Against Medical Advice - # Admitted To Hospital - # Admitted 23 Hr Observation - # Admitted ICU - # Sent To Outpatient - # Admitted To Maternity - # Total Patients
---	--
- ◊ **Emergency Department Statistics** provides a listing of visit information totals for selected period of time:

<ul style="list-style-type: none"> - Date - Discharged - Admitted ICU - Regular Admission - 23 Hr Observation - Sent To Outpatient/OR - Managed Care Denial - Left Without Being Seen 	<ul style="list-style-type: none"> - Left Before Receiving Instructions - Refused Admission - Left Against Medical Advice - Transferred - Expired - Total registered - Left Without Being Registered - Admitted To Maternity
---	--
- ◆ **Mortality Log** provides a listing of the following visit information for selected period of time:
 - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By
- ◆ **Mortality Log** provides the following summary information for selected period of time:

<ul style="list-style-type: none"> - # Expired - # Released - # Transferred - # Left - Managed Care Denial - # Left W/O Being Registered - # Left W/O Seeing Physician - # Left Before Receiving Instructions - # Refused Admission 	<ul style="list-style-type: none"> - # Left Against Medical Advice - # Admitted To Hospital - # Admitted 23 Hr Observation - # Admitted ICU - # Sent To Outpatient - # Admitted To Maternity - # Total Patients
---	--

Transcript Reports

Printing Transcript Reports

Continued from Accessing the Reports Generator, Page 264.

5. Select any combination of reports under "Transcript Reports" at lower center of screen (Transcript Log, Medical Records Without Transcript Logs, Medical Records Waiting For Transcripts, Medical Records Transcript Status).



6. Click on the Print button at the right of screen.

Tips and Hints: Transcript Reports

- (Received and Processed) **Transcript Log** provides a listing of the following visit information for selected period of time:
 - Arrival Date/Time, Dictation Date/Time, Received Date/Time, ED Physician, Admission #, Patient Record Name, #, Patient Dictated Name
- (Received and Processed) **Transcript Log** provides the following summary information for selected period of time:
 - # Total Transcripts
- ◇ **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides a listing of totals for the following visit information for selected period of time:
 - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician
- ◇ **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides the following summary information for selected period of time:
 - # Total Visits
 - # Selected Visits
- ◆ **Medical Records Transcript Status** provides a listing of the following visit information for selected period of time:
 - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician
- ◆ **Medical Records Transcript Status** provides the following summary information for selected period of time:
 - # Total Visits

Daily Report Group

Printing Daily Report Group

Continued from Accessing the Reports Generator, Page 264.

Daily Report Group

- Click on the Daily Report Group button at the right of screen.

The screenshot shows a window titled "Reports" with the "Active User" as "James Ross, Jr., MD". The window is divided into several sections:

- Time Range:**
 - ☐ All (WARNING: Large Quantity Of Pages)
 - ☒ Previous Day (24 Hours)
 - ☐ Current Day To Current Time
 - ☐ Previous Month
 - ☐ Current Month To Current Time
 - ☐ Specified Period
 - Date From:
 - Date To:
- Visit Reports:**
 - ☒ New Visit Log
 - ☐ Visit Status Log
 - ☒ Completed Visit Log
 - ☐ Admitted Log
 - ☐ Patient Statistics
- Specialty Reports:**
 - ☐ Greater Than 6 Hours
 - ☐ Seen Again Within 72 Hours
 - ☐ Emergency Department Statistics
 - ☐ Mortality
- Transcript Reports:**
 - ☒ Transcript Log
 - ☒ Medical Records Without Transcripts
 - ☒ Medical Records Waiting For Transcripts
 - ☒ Medical Records Transcript Status

On the right side of the window, there is a button labeled "Daily Report Group". At the bottom right, there are two buttons: "Print" and "Exit".

Figure Chapter 3: -177: Reports (Generator), Daily Report Group Selected

(Image: reports-drg.bmp)

Print

- Click on the Print button at the right of screen.

Tips and Hints: Daily Report Group

The Daily Report Group option provides the following combination of logs:

- **New Visit Log** provides a listing of the following visit information for the previous 24 hours:
 - Patient #, Admission #, Arrival Date/Time, Patient Name, Sex, ED Physician
- **New Visit Log** provides the following summary information for the previous 24 hours:
 - # Total Visits
 - # Visits Using Beds,
 - % Visits Using Beds
- ◊ **Completed Visit Log** provides a listing of the following visit information for selected period of time:
 - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By
- ◊ **Completed Visit Log** provides the following summary information for the previous 24 hours:

<ul style="list-style-type: none"> - # - Expired - # Released - # Transferred - # Left - Managed Care Denial - # Left W/O Being Registered - # Left W/O Seeing Physician - # Left Before Receiving Instructions - # Refused Admission 	<ul style="list-style-type: none"> - # Left Against Medical Advice - # Admitted To Hospital - # Admitted 23 Hr Observation - # Admitted ICU - # Sent To Outpatient - # Admitted To Maternity - # Total Patients
--	--
- ◆ (Received and Processed) **Transcript Log** provides a listing of the following visit information for the previous 24 hours:
 - Arrival Date/Time, Dictation Date/Time, Received Date/Time, ED Physician, Admission #, Patient Record Name, #, Patient Dictated Name
- ◆ (Received and Processed) **Transcript Log** provides the following summary information for the previous 24 hours:
 - # Total Transcripts
- * **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides a listing of totals for the following visit information for the previous 24 hours:
 - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician
- * **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides the following summary information for the previous 24 hours:
 - # Total Visits
 - # Selected Visits
- ⇒ **Medical Records Transcript Status** provides a listing of the following visit information for the previous 24 hours:
 - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician
- ⇒ **Medical Records Transcript Status** provides the following summary information for the previous 24 hours:
 - # Total Visits

Doctor/Patient List

Printing Doctor/Patient List

From the "Active Patient List" (your main tracking screen)

Utilities

1. Click the Utilities button.

Doc/Patient List

2. Click on the Doc/Patient List button at the left of screen.

Doctor/Patient List

Active User J.E. Ross, MD

"Print List" will print all patients where "ED Physician" in Admission Info match "Target Physician" for the period indicated under "Patients Over Last."

Print List

Patients Over Last:

☐ 1 Day

☐ 3 Days

☐ 7 Days

☐ 14 Days

☐ 1 Month

☐ Specified Period

Target Physician

J.E. Ross, MD

Select ED Physician if Not Active User

Date From

11

Date To

11

Return To Program

Figure Chapter 3: -178: Doctor/Patient List

(Image: doc-patient-list.bmp)

4. Select the Time Range settings for your report (center of screen).
5. Enter ED Physician (refer to pull down menu if other than you).
6. Click on the Print button.

Print

Tips and Hints: Doctor/Patient List

- Doctor/Patient List provides the following visit information for the selected period of time:
 - Visit Date/Time, Admission #, Patient Name, Exit Status

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Chapter 4: Support Services

TeleMed™ Service

Under the TeleMed Service program, RLIS provides support services to your local help desk and users. It's the practical, economical solution for hospitals with distributed information service groups and TeleMed software users. Three levels of support are offered under this program:

- **Platinum Key Support:** Includes toll-free telephone support*, toll-free access to TeleMed's Electronic Services, Remote Services, master copies of all maintenance releases, Quarterly Updates† and periodic upgrades‡ to the current version of your licensed software and On-Site‡ Technical Support. Mission Critical Support includes Level 1, 2, 3 & 4 support†. All clients and servers must be running the current version of TeleMed software when entering the Mission Critical Support program.
- **Gold Key Support:** Includes toll-free telephone support*, toll-free access to TeleMed's electronic services, Quarterly Updates† and periodic upgrades‡ to the current version of your licensed software and "per visit" on-site technical services. Standard Support includes Level 1*, 2 & 3 support†.
- **Silver Key Support:** Provides all Quarterly Updates† and periodic upgrades‡ to the current version of your licensed software and "per call and per visit" technical services. All users must own the current version of TeleMed software when entering the Basic Support program.
- ♦ **Remote Link Discount Option:** When selecting the Remote Link Option, all sites that provide TeleMed dedicated ISDN connection(s) to their TeleMed servers will receive a discount on any of the three support options.

* Level 1 - 24 hr. x 7 day for Mission Critical Support, 8 AM -5 PM CT Mon.-Fri. for Standard Support,
Level 2 & 3 - 8 AM to 5 PM Central Time

† see "Definitions" section of your support contract for descriptions

‡ as determined by TeleMed Service staff

Your hospital's administration group in charge of service contracts will know the terms of your service contract.

Contacting TeleMed Help Desk

You can reach TeleMed support via phone or fax.

Phone: ~~800-495-7541~~ or (210) 490-1800

Fax: 210-495-8899

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Appendix A: TeleMed License Agreement

RLIS and Licensee agree that the following terms and conditions will apply to all computer program products, user manuals, other documentation and services ("Program(s)") provided by RLIS to Licensee including Program(s) specified in any "Schedule" executed by both parties. The term Program(s) also includes any subsequent updates, modifications and enhancements to the Program(s) that are furnished by RLIS to Licensee.

1. **License.** RLIS hereby grants to Licensee a nonexclusive license (the "License") to use the Program(s) internally in the United States in accordance with the terms and conditions set forth in this Agreement and the relevant "Schedule." The License authorizes the use of the Program documentation furnished by RLIS and the use of any subsequent updates to the Program(s) that are furnished by RLIS to Licensee. The License authorizes the Licensee to install or use the copy of the Program(s) furnished to Licensee, and the back-up or archival copy made by Licensee, only on a single central processing unit ("CPU") (or authorized server(s) and workstation(s) under the network option license) identified by machine identification numbers provided by Licensee to RLIS. Installation or use of the Program(s) on more than one CPU at the same time requires a separate License for each such installation or use. Licensee may physically transfer the Program(s) from one CPU to another, provided that the Program(s) reside on only one CPU at a time. Licensee may not install the Program(s) on a network or electronically transfer the Program(s) from one CPU to another via a network, unless Licensee has obtained a network option for the Program from RLIS.

If RLIS delivers a network option for the Program(s) to Licensee, each such option shall consist of a network option license which shall authorize the Licensee to install and operate the Program(s) on the licensed server or workstation part of the Program(s), as the case may be, on a single authorized server or multiple workstations or clients identified by a machine identification number and located at a site provided by Licensee to RLIS so that the Program(s) may be accessed by users only in a network designated by Licensee only by means of the authorized server(s).

Unless otherwise specified in the relevant "Schedule", the maximum number of concurrent users for Program(s) licensed in a network option shall be limited to the maximum number of licenses granted to Licensee and in effect for such Program(s) or, in the case of updates to the Program(s) delivered under Support Services, the maximum number of licenses for which Licensee has purchased Support Services. Use of Programs in a network option by additional concurrent users shall require that Licensee purchase a commensurate number of additional licenses or, in the case of updates, Support Services for a commensurate number of licenses.

Licensee shall promptly notify RLIS of any changes in the machine identification number or location of the authorized servers(s) or workstation(s) or CPU(s) from the one originally specified. If Licensee wishes to substitute a different authorized server or workstation or CPU under this Agreement, Licensee shall notify RLIS and RLIS shall either provide the Program(s) on the different authorized server or workstation or CPU or enable the existing Program(s) to operate on the different authorized server or workstation or CPU as soon as reasonably practicable and Licensee shall pay RLIS the amount, if any, specified in the relevant "Schedule" attached hereto.

The Licenses cannot be assigned, sublicensed or otherwise transferred to another person or legal entity without the prior written consent of RLIS, except that Licensee may permit its majority owned subsidiary to exercise any of Licensee's rights under this Agreement, provided that (i) such subsidiary agrees (in a writing provided to RLIS if so requested) and Licensee hereby represents that subsidiary will comply with all the terms and conditions of this Agreement, and it does so comply, (ii) Licensee shall be liable for any violations of the terms and conditions contained herein, and (iii) no such subsidiary is in either direct or indirect competition with RLIS as a provider of computer-aided software engineering products or products to develop, implement and maintain business critical information systems.

The Program(s) may contain an automatic shut-off or time out feature which will disable the Program(s) after a predetermined period of time if Licensee fails to provide RLIS with CPU, server or workstation or other machine identification numbers.

2. **Term.** This Agreement shall commence as of the date upon which this Agreement is signed by both parties and this Agreement and the License(s) shall continue unless and until terminated pursuant to the provisions set forth in this Agreement.

3. **Charges.** All fees are payable in US dollars. Upon receipt of the Program(s), the license and/or service fee payment terms set forth in the "Schedule" shall be due and payable. Payment shall be made at the office of RLIS, Inc. at 4319 Medical Drive #131-341, San Antonio, Texas 78229, or as otherwise directed by RLIS, Inc. in writing. Should Licensee request that delivery of the Program(s) occur more than thirty (30) days after execution of the "Schedule", such fees shall be subject to any changes in RLIS' commercial list prices. Licensee shall pay all sales, use, excise, and similar taxes applicable to the Program(s) and this Agreement and shall reimburse RLIS for any such taxes paid by RLIS, excluding taxes based on the net income of RLIS.

4. **Delivery.** RLIS shall deliver the computer programs to Licensee in the form of CD-ROM(s), diskette(s), or tape(s) containing machine readable code F.O.B. San Antonio, Texas, USA. In addition, RLIS shall provide Licensee with one set of RLIS' current user manual(s) for each computer program licensed hereunder describing the operation and use of that computer program.

5. **Installation.** RLIS shall install the computer programs as set forth in the Performance Criteria Checklist attached to this Agreement and executed by the parties.

6. **Protection of Program.** Licensee acknowledges that RLIS retains all title, copyrights, patents and other proprietary rights in and to the Program(s), including any and all copies, updates, modifications, enhancements, translations and other derivative works that duplicate or are based thereon. If RLIS provides consulting services, including on-site services or training services (collectively, the "Consulting Services") in connection with Licensee's use of the Program(s), such Consulting Services shall be provided at RLIS' then current rates. Licensee agrees any updates, modifications, enhancements, and translations to the Program(s) shall be the sole and exclusive property of RLIS, subject to use by the Licensee under

the terms of this Agreement. Notwithstanding the foregoing, RLIS makes no claim of any proprietary rights in the output generated by Licensee's authorized use of the Program(s) or other code created by use of the Program(s).

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